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THE

# MEDICAL JOURNAL OF AUSTRALIA

(With which "The Australasian Medical Gazette," and "The Australian Medical Journal" are incorporated.)

The Journal of the Australian Branches of the British Medical Association.

VOL. I.—4TH YEAR—No. 9. SYDNEY: SATURDAY, MARCH 3, 1917. PRICE 6D.

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# THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—4TH YEAR. SYDNEY: SATURDAY, MARCH 3, 1917. No. 9.

## Presidential Address.

By George E. Clemons, M.D., C.M. (Edin.),
*Retiring President of the Tasmanian Branch of the British Medical Association.*

Custom compels the retiring President of this Branch of the Association to deliver an address annually, and I am in agreement with those who think it right to keep up the custom, because occasionally it may bring forth something worthy of the occasion. I have not compiled an address with that object in view, and to those who have any apprehensions about having to listen to a long dissertation I can give immediate re-assurance. At the same time, I feel that after nearly a quarter of a century of practice in Tasmania, and having started my medical career as House Surgeon in the Hobart General Hospital, I should at least have some claims on your forbearance, if I were to adopt the rôle of the old man, and to tell you, and the younger ones of you more particularly, of the things that used to happen in medical practice, and the excellence of them in times gone by. However, it is on the opposite condition of affairs that I feel it is much more fitting to congratulate ourselves, and though I cannot pretend to give even a sketch of the increase in medical knowledge during that time, I would like, even at the risk of boring you somewhat, to give a few details to back up my assertion that those who are in practice now, and especially those who are beginning, are in so much more fortunate a position than we were twenty-five years ago, fortunate mainly in this respect that we are able to do so much more for our patients than we were. To take that branch of the profession, which we, all of us here, are so familiar with, *viz.*, that of midwifery, I would call to your recollection that there was not in Tasmania at that time a maternity hospital or home, to say nothing of a trained midwifery nurse. How much the establishment of these have added to the safety and comfort of patients, to say nothing of the profession, it would be hard to exaggerate. I hope to keep out of this address "The Almighty Ego" as far as possible, but I may be pardoned for saying that the Queen Victoria Hospital in Launceston was the first one to be established in this island, largely owing to the efforts of philanthropic women, supported by the late Dr. Wilson, by Dr. Hogg and by myself, and, strange to say, in the teeth of opposition from the public and some of the profession. Two comparatively recent introductions have had a most marked effect in the conduct of midwifery cases, and are, in my opinion, most valuable therapeutic agents. I refer to pituitrin, which finds its greatest use in multipara with a well dilated *os*, and in the later part of the second stage, and the other, scopolamine and morphine, which finds, on the contrary, its greatest use in primiparæ and the early part of the first stage of labour. What extreme value, too, has pituitrin in breech presentations, and in preventing that dread complication, post-partum hæmorrhage. It is no exaggeration to say that the conduct of midwifery cases in our days is neither so tedious, so dangerous, nor so anxious as it used to be. If then, we have got rid of so much trouble in our midwifery cases, with how much greater assurance of being able to give relief do we approach surgical cases. Just to mention a few. Uterine fibroids were left mainly to ergot and resignation; gallstones to morphine and resignation; prostates to the catheter and untold misery. Goîtres were surgically severely left alone. Hernias were treated by trusses in 90% of cases. Now quite 90% are treated and cured by operation, with practically no mortality. What great advances there have been made in the surgery of the stomach and bowel, tendon and nerve suture, transplantation of bone, ankylosis of joints; and in connexion with these branches of surgery I would like to bear testimony to the most excellent work which has been done by my friend, Dr. Sweetnam. The majority of operations on the nose and its accessory cavities, with their highly beneficial results, were practically unknown. The vastly improved technique of local anæsthesia, spinal anæsthesia, have contributed largely to our success in surgical procedures. Nor must it be thought that medical science has been standing idly by; the clinician, with the aid of the bacteriologist, has made it possible for us to tackle with assurance many diseases we dreaded to approach. Think of the multitude of lives that have been saved in diphtheria—a disease we used to dread. The establishment of sanatoria has already made the incidence of consumption far less, and promises to make its extinction within our reasonable hopes. Salvarsan and salvarsanized serum promises to do something similar with syphilis. New discoveries in connexion with the cardiac ganglia, the bundle of His, have helped to make our diagnosis, prognosis and treatment of heart disease much more successful. The significance of albuminuria, with or without chlorides, enables us to differentiate kidney diseases with greater accuracy.

The sphygomanometer is now in daily use in our consulting-rooms—no longer a toy for a few physiologists. We have had in our midst recently a disease we have long been dreading—epidemic cerebrospinal meningitis. Already the bacteriologist has enabled the clinician to achieve far better results in this than formerly. What incalculable benefit to us are the X-rays in the diagnosis and treatment of disease, and every day some new improvement in it, and especially the Coolidge tube, seems likely to add still further to its usefulness. On the whole, then, it would be idle for us to ignore the fact that the medical profession is not only much more capable for good than it ever was, but, without flattering our-

[1] Read at the Annual Meeting of the Tasmanian Branch of the British Medical Association on February 13, 1917.

selves, we can fairly believe that it is much higher in public esteem than it ever was. The testimony of newspapers and military men is unanimous in its praise of the capability of medical men in the management of the health of the troops in this war and the treatment of the injuries inflicted.

And here I may say the greater our power for good the greater our responsibility, and it behoves us all to safeguard the interests of the public by not doing operations that could by any means be called questionable, and, at the same time, jealously guarding the good name of the profession.

Even legislators have come to recognize the fact that sometimes our advice may be worth accepting. I may instance the Bill dealing with venereal disease. The mention of this leads me naturally to some questions of medical politics, which I think we ought to take a hand in. I presume we are all agreed that it would be very beneficial to the community, if we had established here in Tasmania, as elsewhere, a sanatorium for the treatment of early mental and nervous cases—cases shunned by both public and private hospitals. Such an institute would, in the long run, be a saving to the State, by reducing the number compelled later to enter New Norfolk. Nor would it bear the stigma attached to such institutions. These early cases are just the ones which the general practitioner meets. Two measures proposed to be dealt with by the Government call for some comment by this Society. One, the establishment of an infectious diseases hospital, managed and staffed and under control of the General Hospital, is, in my opinion, an egregious error. It should be under the control of the Local Government Board. The other is the notion that the Venereal Diseases Bill can be properly carried out without a bacteriologist in the North. This statement is, I am sorry to say, made on the authority of Dr. Cumpston. Northern practitioners have for a long while felt the need of a public bacteriologist, and I feel confident that for the purposes of the Bill alone he would find ample work.

We had during the early part of the year a visit from the Editor of *The Medical Journal of Australia* and an address on medical politics from him, both North and South. I wish here to thank him for his courtesy and, more so, for his able presentation of the facts of the case in the controversy connected with the Launceston General Hospital. We are still in the throes of a struggle against the nationalization of the medical profession, and I cannot help thinking that, if there is one question which will enable us to keep a solid front and gain our ends, it is this one. If the profession fail to unite on it, I shall for ever despair of its doing so. We have had the pleasure of sending our congratulations to our esteemed Tasmanian colleagues at the front; we have reason to be more than proud of them.

Before concluding, I wish to thank members for their invariable courtesy and forbearance with me while occupying this chair, and especially to thank our Secretary. We Presidents are annual, but he is perennial, and it is a good thing for us it is so. I may add that while I leave the Chair with some regret, the Association is to be congratulated on its choice of our new President. I feel sure he will hold the balance fairly, between conflicting interests, and conduct our business as worthily as any of his predecessors.

## A PECULIAR "BLUE-SPOT" ERUPTION OBSERVED IN SOLDIERS.[1]

By **Herman Lawrence, M.R.C.P. (Ed.), etc.,**
*Dermatologist, St. Vincent's Hospital, Melbourne.*

Early in August of last year Captain Trewhella, who was in charge of the isolation wards at the Base Hospital, St. Kilda Road, asked me to see one of the soldiers under his care, with what he termed a "blue-spot" eruption.

Since that date there have been three similar cases, and as the symptoms of all four cases are so very alike, I am describing the four cases at the same time. The patients were soldiers, sent to the isolation ward as suspects of cerebro-spinal meningitis.

On admission there was, in each case, an elevation of temperature, varying from 101° F. to 103° F.; this feverish period lasted about three or four days. On the temperature becoming normal the patients felt comparatively well.

From two of the patients meningococci were obtained from the throat; but none of them developed symptoms of cerebro-spinal meningitis. Captain Trewhella says the throats of all four patients showed the clinical appearances as met with in the throats of abortive cerebro-spinal meningitis. In no case was the eruption present when the patient was admitted. Captain Trewhella is quite certain upon this point, as he examined each patient carefully when admitted for any evidence of a cerebro-spinal meningitis rash. The rash appeared on the second or third day after admission.

The eruption was macular in type, the individual lesions being of a slate blue or steel grey colour, and not palpable, giving rather the appearance of a depression in the skin. The macules varied in size from that of a split pea over the abdomen to that of a sixpenny piece on the lumbar regions and the back of the thighs.

The eruption appeared upon the abdomen and sides of the chest, small of the back, the buttocks, back and front of the thighs. It was not accompanied by any symptoms. It appeared quickly over the parts mentioned, only a few spots developing later.

The spots did not disappear upon pressure, although they did not become more evident under pressure with convex glass, as is the case of purpuric spots. The spots remained the same colour for several weeks (three or four), and then very gradually disappeared, some being still noticeable up to the seventh or eighth week.

The spots had the appearance of the rash known as *tache bleuâtre*, which is attributed to the action of pediculi, the *pediculus pubis* in particular. In fact, the rash was so like the *tache bleuâtre* that a coloured plate depicting this eruption in Murchison's "Continued Fevers" (1884) could well be used to illustrate any one of these cases.

[1] Read at a meeting of the Victorian Branch of the British Medical Association, on February 7, 1917.

Colonel A. V. Anderson, Senior Physician to the Base Hospital, who saw three of these cases with me, said he had seen similar spots in cases of typhoid fever, and had reported his cases as *taches bleuâtres* in the *Australian Medical Journal*, 1894. Other writers report *taches bleuâtres* occurring in typhoid, and no doubt the reason this condition has been noticed in particular in typhoid is on account of the careful search made for the usual rash occurring in this disease. Jacobi says *taches bleuâtres* soon disappear spontaneously. I kept my cases under observation for eight weeks, and some of the spots even then had not quite disappeared.

Osler says that he had never failed to find some evidence of pediculi in all cases of *tache bleuâtre* that had come under his observation. *Tache bleuâtre* has been produced experimentally by crushing up specimens of *pediculus pubis* and inoculating them into the skin with a lancet, showing that some poisonous substance in these parasites has the effect of producing this peculiar blue-spot colouration of the skin.

However, Captain Trewhella and I are quite sure that no pediculi were present in any of our cases, and, as a matter of fact, although the *pediculus corporis* and *capitis* are frequently met with, I very seldom have any cases of *pediculis pubis* in Melbourne.

In my paper, "*Remarques Particulières aux Maladies de la Peau en Australie*," which appears in the transactions of International Dermatological Congress, Rome, 1912, I mentioned that there occurred in my practice only six cases of *pediculus pubis* in 6,000 consecutive cases of skin disease.

Stelwagon (7th edition) says: "The view held as to the spots being hyperæmias or hæmorrhages is not supported by their appearance or behaviour," and, quoting Duguet, that they are simply pathognomonic of the presence of the crab-louse.

It appears to me that present-day literature tends to confuse under the heading *tache bleuâtre* two conditions of the skin which, though clinically very similar, are ætiologically quite distinct the one from the other. The two conditions are:—

(*a*) *Tache bleuâtre pediculorum*, the blue colour being due to a stain produced by the *pediculus pubis*.

(*b*) *Tache bleuâtre*, generally occurring in feverish conditions, the colour being due to some peculiar hæmorrhagic condition.

This opinion has been forced upon me by the fact that in the cases I publish there was no pediculosis. Of this fact I have no doubt whatever, and *pediculosis pubis*, as I have already indicated, is an extremely uncommon occurrence in Melbourne.

## DERMATOLOGY ON ACTIVE SERVICE WITH THE R.A.M.C.[1]

By **Roland R. Wettenhall, M.B., B.S.,**
*Melbourne.*

I have labelled my notes "Dermatology on Active Service with the Royal Army Medical Corps." Being in England at the outbreak of war, I joined the Royal Army Medical Corps. Naturally, the practice of dermatology was not very specially in my mind; but on reviewing 17 months' work at home and abroad, skin diseases take a place of some importance. It is advisable to outline the facilities for treatment of skin cases as they are arranged in the Army.

### At Home.

Commencing with the medical officer of a unit, he had his inspection-room, where an orderly helped to dispense simple remedies, and where conditions such as *impetigo contagiosa* could be treated. Cases of scabies were isolated in a hut or tent, and treated in the camp as a rule.

Men incapacitated from walking by conditions of a temporary character, such as an abscess, were kept in a detention hospital in the camp, with a trained orderly and a good supply of drugs, whereas in more severe or chronic cases the men were sent to the General Hospital, and those suffering from infectious disease were sent by special ambulance to the Isolation Hospital.

In the Aldershot Command there were two General Hospitals, with a dermatologist at each. All patients with venereal disease were sent to one of them, and at this hospital there was an assistant responsible for syphilitic cases. There were also wards for scabies, attendants for these cases, and special baths. X-rays were available for treatment, but were in charge of the skiagraphist.

The Isolation Hospital, with over 500 beds, received patients with cerebro-spinal fever, measles, scarlet fever, etc., as is usual.

### Abroad.

The medical officer of a unit carried his equipment on a Maltese cart, and usually found comfortable inspection-rooms. Any reasonable need could be obtained by requisitioning the field ambulance. In the trenches a dug-out and first-aid was all that was available. The field ambulances were housed in substantial buildings as a rule, rapidly transformed for hospital use, and there they undertook treatment of temporary conditions, such as scabies.

There were three field ambulances to each division, so that each field ambulance cared for approximately 5,000 men.

In each division, too, there was a sanitary section, with a medical officer in charge, and baths were arranged, where clean underclothing could be obtained and the clothes were ironed when infected with pediculi.

Infectious diseases were sent to special hospitals, and venereal diseases to a special camp at the base, as also were self-inflicted injuries.

Official military manuals give directions clearly and concisely to all branches of the service in such matters as first-aid for burns and on sanitation.

Pamphlets are issued with directions for prevention of such new conditions as trench feet, and strict orders are given that the precautionary measures should be carried out by the commanding officer. This, of course, is necessary, as the medical officer of a unit is only an adviser to the commanding officer, and is not officially responsible for his advice

[1] Read at a meeting of the Victorian Branch of the British Medical Association, on February 7, 1917.

being carried out. When a man is put on the sick list, then the Royal Army Medical Corps takes charge of him, but not before.

The presence of skin diseases to some extent depend on the fact that early in the war accommodation was inadequate; consequently, the men were very crowded in barracks, making the spread of scabies and pediculosis easy. They were well clothed and food was superabundant; baths with hot water were available in the barracks. Much of the troops' time was occupied in marching, besides squad drill and similar exercises, necessitating good management of feet. The winter was very wet and as cold as usual, yet chilblains and frost-bite were practically non-existent. When summer came accommodation was much extended by the use of tents.

Abroad, of course, accommodation varied from bedrooms (rarely) to barns in various stages of repair, and the trenches with their dug-outs, as a rule infested with mice and rats. Clothing was excellent and diet adequate. Troops are not left long in the same billets, and have to clear up on leaving; they are fully exercised when in back billets by road marches. The medical officer finds that care of the men's feet is an important part of his duties with the infantry. There is an excellent official manual on chiropody; one or more men are trained as chiropodists to each battalion, and a special set of instruments is provided. In addition, we had boot-makers with us, so that alterations and repairs could be made on the premises, so to speak. Numbers of men with hammer toe managed quite well.

It was difficult to get some men to wash their feet, as the idea prevailed that doing so softened the skin; but where the feet perspired freely, bathing and frequent changing of socks were necessary. Boots were softened with castor oil, and were made to fit well round the ankle, with plenty of room for the toes.

With regard to trench feet, I saw none, although the men were as long as ten days in the trenches at a spell, and snow was on the ground continuously for six weeks. The condition was described and measures for prevention laid down in special pamphlets issued for the Army.

I got our officers and non-commissioned officers together and gave demonstrations of rubbing in grease and the reason for it, but consider that the condition of the trenches counted for much, being dry and in some places boarded. It was considered a crime to be affected.

One pest is the ever-present louse. The *Pediculus capitis* was practically absent, as I do not remember one; the men's hair was kept short, but not shaved. *Pediculus pubis* was there sometimes, very strongly entrenched; but *Pediculus corporis* was the general variety found. Its spread was helped by the fact that men could not retain their own blankets when marching, as their packs were so heavy. Consequently, their blankets got mixed on the waggons which carried them from place to place. As frequently as possible the men were given hot baths and a clean change of underclothing, and infected trousers were ironed along the seams to destroy the eggs. Infected clothing was treated by Thresh disinfector. The older soldiers were inclined to treat its presence lightly, but I pointed out to them that it played a considerable part in transmitting disease.

A whole company was paraded at one time for inspection, and passed by in single file, with neck and shoulders bare; the affected men could readily be picked out from excoriations seen.

Cases of German measles occurred sporadically through the winter, and though isolation of contacts was carried out as often as possible, it was not very successful. Minute particulars of each case had to be reported to the Acting Director of Medical Services of the Division, and disinfection of the billet was carried out by the Sanitary Section.

The absence of syphilis was notable amongst the troops I was with in France and at home too.

There was no scurvy nor any condition of an allied nature, as there was an abundant supply of potatoes and fresh meat in the diet; bully beef and Maconochie's rations were issued, the latter often being a mixture of vegetables and meat in 1 lb. tins. Some attacks of diarrhœa were put down to this ration; but I saw no skin affection caused by food poisoning.

One case of recurrent facial œdema occurred in the carpenters employed with the battalion; but I considered it due to external irritants.

Onychia, with an associated lymphangitis, accounted for some cases; but by removing the nail and applying antiseptic foments I managed to save sending the patients to hospital.

Eczema was remarkable as an absentee, there being very few cases.

Seborrhea was not so rare; but it did not cause any incapacity.

Kerion occurred sometimes, no doubt derived from the horses, as those affected were in the transport.

One case of epithelioma was met with in a middle-aged man who had an old wart on the palm of his hand.

A generalized mercury dermatitis followed the rubbing in of *unguentum hydrargyri* for *Pediculi pubis* in two cases.

Urticarial and erythematous conditions were seen after inoculations for typhoid; but not very frequently.

Psoriasis occurred in a few cases. The men were not taken off duty, save when this affection was severe.

*Impetigo contagiosa* was not rare, but by strict treatment was prevented from causing much trouble.

Artificial eruptions were not encountered, though self-inflicted injury was not unknown.

In only one case did I have trouble with intertrigo of the groin; the man did not report sick until we were on the march.

The skin diseases wards at the General Hospital at home were occupied mainly by scabies, which was treated very successfully with balsam of Peru derivative instead of sulphur. Eczema, psoriasis, *impetigo contagiosa*, sycosis and syphilis were the principal other conditions.

At the Isolation Hospital, where I spent five months, measles, German measles, scarlet fever, and cerebro-spinal fever were seen.

The eruptions in cerebro-spinal fever were not as frequent as we are sometimes led to expect, and the marked purpuric eruption was the exception rather than the rule.

Occasionally cases of flea-bites were sent up as German measles, and a case of *erythema multiforme* was sent as cerebro-spinal fever.

On the hospital ship, in which I had charge of 74 patients, the only skin condition I remember was a case of burns from high explosive, which were extensive but superficial in character.

Looking back on the various conditions met with, the total of skin diseases is seen to be considerable, and a knowledge of dermatology of great use to medical officers.

## Reports of Cases.

### DUODENAL ULCER COMPLICATING BURNS IN AN INFANT.

By **Ivan E. Ashby, M.B., B.S. (Adel.),**
*Resident Medical Officer, Adelaide Children's Hospital.*

D.S., female, aged 11 weeks, was admitted to the Adelaide Children's Hospital on May 28, 1916, suffering from severe burns.

The previous history and the family history were negative. Up to the time of the accident the baby had appeared to be quite normal.

Forty-eight hours before admission, on board ship, the father, while preparing a bottle for the child, upset the contents of a "thermos" flask over her. Some first-aid was rendered on board.

On admission to the hospital the baby was suffering from extensive superficial burns, involving almost the whole of the face and neck, including both ears, part of the scalp the left shoulder and arm, and a portion of the back. The whole was smeared with a mixture of pus, blood, flour, oil and rag. The temperature was 103.4°, the pulse-rate 148, and the respiration 42.

Duodenal Ulcer from baby aged 13 weeks who died of burns 17 days after the accident.

The usual treatment for burns was instituted. The majority of the burnt areas began to clear up well; massive adherent sloughs, however, developed in those on the neck and shoulder, and very feeble efforts at repair were made. The child took its nourishment (milk and water) surprisingly well till just before death. The motions at first were yellow, becoming greenish after a few days. The temperature continued to be irregular, varying between 98° and 102°. The patient vomited four times; once on May 30, once on June 1, and twice on June 5 (all food vomits).

On June 5 her condition became worse. The pulse was much weaker; she was distended, and vomited twice. In the evening she passed some dark blood in her motions. The two or three following stools were tarry.

Two days later a panophthalmitis developed in the right eye. The child continued to get worse, and died on June 11, 1916, 17 days after the accident. There were no further hæmorrhages from the bowel. The cause of death was evidently toxic absorption from the burnt surfaces. The distension had been relieved.

A complete autopsy was refused, but permission given to examine the duodenum for ulcer. The post mortem findings were as follows:—

There was an ulcer situated on the lower side of the duodenal aspect of the pyloric sphincter. It was almost circular, measuring 13 mm. in diameter and of the punched-out variety. The margins were quite sharply defined and vertical; the mucous membrane was not undermined. The base was smooth, composed of submucous and muscular tissue, deeper in the middle, where it was very thin. The average depth was 2 mm. No vessel was to be seen to account for the hæmorrhage. There was little or no thickening around the ulcer.

I have to thank Dr. A. C. Magarey for permission to report this case.

## Reviews.

### MYOPIA.

Argumentative and controversial treatises need to be read with more than usual care, firstly to get the author's point of view and follow his reasoning, and secondly to guard against specious logic and faulty deductions. Such is the reviewer's feeling in reading Dr. Muirhead's interesting brochure on extra-ocular pressure and myopia,[1] in which the author sets out to disprove the theory that myopia is due to the action of the ocular muscles, in accommodation and especially in convergence, causing elongation of the eyeball. Without being wedded to this theory, we cannot think that the author has convincingly proved his point, that, far from producing elongation of the eyeball, convergence actually causes shortening. Whichever view may be correct, a matter to be thrashed out by physiologists, we cannot escape from the broad clinical fact that close work produces myopia and causes the increase of myopia. Other causes, too, are generally accepted, especially heredity, muscular debility and bad hygiene. The application of the author's gospel is far from clear; surely he does not advise his myopic patients that the more they read the better for them!

General agreement will be given to his condemnation of over-myopic correction that causes discomfort and pain during near work. The book should encourage fresh physiological and statistical work on this pressing and ever-green subject. Many interesting facts are brought out in the ninety-two pages of reading matter, especially in Chapter II., on the apparent size of objects. The author's curious optimism may serve as a check to the perhaps over gloomy prospect usually held out to the astonished and frankly sceptical myope.

## Hospitals.

### THE SYDNEY HOSPITAL.

The annual report of the President and Board of Directors of the Sydney Hospital for the year 1916 was submitted to the subscribers at the annual meeting held on February 20, 1917.

The Board of Directors point out that the year 1916 has been one of great anxiety on account of the financial position of the institution. It had been hoped that assistance would have been forthcoming, since a Minister of Public Health, before relinquishing his office, announced that the sum of £52,656 had been placed on the Estimates by the Government for the purpose of freeing the Hospital of some

[1] Extra-ocular Pressure and Myopia. By Islay B. Muirhead, M.D.; 1916. London: John Bale, Sons & Danielsson, Ltd., Oxford House. Crown 8vo., pp. 96. Price 3s. 6d. net.

of its financial obligations. The Minister had promised assistance, and had urged the Board not to curtail its services, but rather to temporize until the Government could assist them to clear off the overdraft at the bank. The contribution from the Government was more than £20,000 less than the sum mentioned. The overdraft at the bank amounts to £27,515, and it is anticipated that before the end of the year it will have increased to £35,000. The Board is grateful to the many subscribers to the Hospital for their contributions. The charitable public have given £5,801 to the Hospital, the patients have contributed nearly £5,000, the students' and other fees aggregated to £354, and the sum of £2,136 was derived from rent, interest, etc., and these amounts, together with the legacies and other receipts, made up a total income of £13,826, excluding the grants and subsidies from the Government.

The following paragraph is significant:—

> Although there has long existed an absolute necessity for extra accommodation in all Departments of the Hospital, the Board recognizes that the time is inopportune, by reason of the appalling war burdens the community is forced to shoulder, to call upon the public to meet this necessity, but the Board is none the less determined, whilst it has the confidence of the citizens and the support of the subscribers, to see to it that any attempts, whether resulting from ignorance of the magnificent work the institution has for over a century done and is still doing, or from any insufficient cause, shall not succeed in diminishing its usefulness.

The lamented death of one of the Vice-Presidents of the Hospital, Mr. S. E. Lees, is recorded. Mr. A. E. Jaques was appointed to fill his position. The changes in the honorary medical staff include the resignation of Dr. G. Lane Mullins, of Dr. B. J. Newmarch, of Dr. E. H. Binney, and of Dr. H. C. Adams. Dr. T. Storie Dixson was appointed temporarily to Dr. Lane Mullins' position. Dr. J. Gordon Hill and Dr. H. R. Beatty were appointed temporary honorary assistant surgeons.

The Directors make a sad reference to the loss of the Hospital by the death on active service of J. E. Donaldson, Muir Smith, N. W. Broughton and Roger F. Hughes.

Short references are made to the work carried out in the various special departments of the Hospital and a list of the conditions found at post-mortem examination is appended. The number of new students enrolled in the clinical school was 20. The number of nurses on the staff at the end of the year was 121. In addition, details of entertainments, etc., are also given.

In regard to the actual work carried out in the Hospital, it appears that there were 5,604 patients admitted during the year. There were, in addition, 316 in the Hospital on January 1, 1916. Of the total number, 5,135 were discharged and 471 died. The mortality was therefore 8.4%. Eighty-four of the patients died within 24 hours of admission; the mortality, excluding these deaths, was therefore 6.9%. Of those discharged 3,544 were stated to have been cured, 1,326 were stated to have been relieved and 265 to have been unrelieved. The average number of occupied beds was 336, and the average duration of the stay of patients in the Hospital was 16.5 days. The maintenance calculated on the total cost, excluding that of the upkeep of the Regent Street Dispensary and the Moorcliff Ophthalmic Hospital, amounted to £49,452. Of the basis of the average number of occupied beds, it would appear that the average cost per patient per diem works out at just under 8s. 1d.

The total number of out-patients attended aggregated 16,364 and of casualty patients 29,777.

## ROYAL NORTH SHORE HOSPITAL OF SYDNEY.

We are indebted to the Secretary of the Royal North Shore Hospital of Sydney for a copy of the annual report for the year 1916, which was presented to and adopted at the annual meeting held on January 29, 1917.

During the course of the year 1,357 persons were admitted into the wards of the Hospital. There were 88 patients under treatment on January 1, 1916, and on December 31, 1916, there were 80 patients still under treatment. There were therefore 1,365 patients in whom the treatment was completed. Of these 105 died, including 33 who died within 48 hours of admission. The mortality, caculated according to the usual formula, works out at 7.7%, or if the deductions are made in respect of deaths occurring within 48 hours of admission, at 5.3%. The figures given of 4.9% is based on the error of including the total number of persons dealt with, without making allowance for the fact that several were still under treatment at the end of the year. Of the 1,260 patients discharged, 829 were stated to have been cured, 357 to have been relieved, and 74 to have left the institution unrelieved. The average number of patients resident in the Hospital was 99.3, and the average length of residence was 24.9 days. In the Out-patients Department 2,615 persons received treatment.

The Board express their gratification that the Government has at length made provision for the extension of the wards for the treatment of patients suffering from infective diseases. The Hospital is the only institution in the northern suburbs of Sydney where these cases can be dealt with. The existing accommodation comprises eight beds in a temporary wooden structure. It has been necessary on several occasions to admit as many as 23 patients at a time, and these patients were suffering from various infective diseases. The sum of £1,000 has been included in the Estimates for the provision of some extra accommodation. In the course of the year 156 patients were treated in this department.

From the report it appears that a large amount of work has been carried out in the Tuberculin Dispensary and in the Ear, Nose and Throat Department. Plans have been prepared for the equipment of a Radiographic Department, and funds are being collected to enable the Board to purchase the necessary apparatus. Good work is reported from the Pathological Department. The Minister of Health has caused plans to be prepared for a clinic for the treatment of venereal diseases, after the Board had expressed its willingness to establish a department for this purpose.

The only change in the honorary medical staff which has taken place during the year is the appointment of Dr. Richard Arthur to the position of Honorary Surgeon to the Ear, Nose and Throat Department.

Only minor alterations and additions have been made in the course of the year. A steam disinfection apparatus has been installed, and is rendering good service.

In recording their gratitude to all those whose services have contributed to the value of the institution, the members of the Board make a graceful allusion to the small services rendered without remuneration, the value of which they state is in direct proportion to the circumstances of the persons rendering the service.

Attached to the report is the financial statement. The cost of maintenance per patient was just over £87. The cost of food stuffs is responsible for a considerable increase in the expenditure. The ordinary expenditure, including maintenance, salaries and wages, and dispensary, domestic and establishment charges amounted to £8,942, and the extraordinary expenditure to £479. The year was started with an overdraft of £299, and terminated with an overdraft of £1,193. The Government contributed £3,753 out of a total income of £8,309. The patients contributed £1,264, and the charitable public just over £3,000. It is stated that the members' subscriptions amounted to a larger sum than that received in 1915.

## OLD GOLD AND SILVER WAR FUND.

We have been reminded that the Old Gold and Silver War Fund has been established with the object of assisting the War Chest Fund with means to carry out its magnificent task. The War Chest Fund is in need of money, and there are more ways than one to supply it. One of these ways is to send odd bits of gold or silver, no matter whether broken or not, whether small or large, whether of low value or of high intrinsic worth, to the Old Gold and Silver War Fund, City Mutual Chambers, 62 Hunter Street, Sydney, or to leave a parcel containing these odd bits at any country or suburban Branch of the Bank of New South Wales or of the Commercial Banking Company of Sydney. In the mass these oddments represent more money than is usually supposed. Why not give it indirectly to our fighting brothers?

The Medical Journal of Australia.

SATURDAY, MARCH 3, 1917.

## The Army Medical Services.

Criticism has been levelled against those in authority in all branches of the military services since the war began. Criticism serves a highly useful purpose, provided that it is undertaken with a full acquaintance of the conditions and with an honest desire to bring about a better state of affairs. If the criticism proves to be unfounded or based on views which cannot be accepted by the majority of those who have given the matter criticized careful study, no harm is done, and it may be that improvements may be suggested in this manner, which might not have been regarded as expedient or necessary under other conditions. The report issued in October last by Colonel Herbert A. Bruce, the Inspector-General of Medical Services of the Canadian Expeditionary Forces, has had a salutary effect, in that the question of the advisability of segregating Canadian soldiers when sick or wounded has been thoroughly enquired into and the practice now obtaining investigated by a Board of eminently expert officers. As is explained by our Special Correspondent in Montreal, the majority of the adverse opinions expressed by Colonel Bruce have not received confirmation by the Board of Enquiry, although the Board concurs with him in regard to the imperfect manner in which the medical examination of recruits has been carried out, and to the unsatisfactory system obtaining in connexion with the medical boards. The history of this enquiry is of considerable interest to the Empire as a whole, and it may be utilized as a basis for analysing the methods of practice in the Australian Army Medical Services.

From the *Canadian Medical Association Journal* we learn that theoretically the idea of segregation of Canadian soldiers needing hospital treatment finds favour among many, but it is admitted that in its pure form it is neither practicable nor desirable from a military point of view. The Board of Enquiry failed to recognize any disadvantage in placing Canadian soldiers in English hospitals when circumstances rendered this procedure advisable, and from the point of view of economy they decided that segregation would be distinctly inexpedient. The *Canadian Medical Association Journal* expresses some surprise that a compromise known as the Australian procedure was not suggested. It appears that arrangements have been made by the Commonwealth authorities and the War Office whereby Australian soldiers may be distributed through English hospitals only in groups of six or more, in order that none of our men should feel themselves isolated. This arrangement acts as a safeguard and as a link as well, and is eminently satisfactory in the medical interests of those needing treatment. The best results can only be attained if the medical officers of all the branches of the service can keep in intimate touch with one another, and if observation, research and the application of new measures are shared by all engaged in war work. The appointment of Australian officers to English hospitals, as well as to Australian hospitals, ensures a constant intercourse between them and their English colleagues, and in a similar manner the admission of Australian soldiers to English hospitals entails the opportunity for a more intimate acquaintance of them and their English comrades, which will be beneficial for both parties.

The incident of the enquiry has focussed attention to the standard of medical examination of recruits in Canada. Excuses have been put forward for the passing of men who proved to be unfit for active service, and, in view of the keenness of the men concerned, it would seem that harm was done in very few instances. The question of the standard of fitness for active service has been discussed and rediscussed in the Commonwealth over and over again. Instances can be provided in numbers of men with defects rendering them unable to stand the severe strain of a great offensive being accepted and sent to the front, as well as of men with but trivial defects of no consequence being rejected. We have called attention to Colonel Maudesley's excellent memorandum on the defects which may be regarded as causes of unfitness from the military point of view. The standards in regard to surgical defects

have also been drawn up. There can be no doubt that it is wasteful and useless to admit of leniency in passing men who cannot be expected to carry out the duties required of them. It must, however, be remembered that it is by no means uncommon for men to undergo the severest strain and the greatest hardships with obvious defects and to serve usefully as combatants. At the present time a very large percentage of volunteers are "turned down" at the medical examination, and it would be interesting to know exactly what the grounds for refusal have been. Given the urgent need for men and a limited number of men willing to offer their services, it follows that very definite reasons should be presented before a single man is entered on the lists as "unfit for military service abroad."

## THE TASMANIAN HOSPITALS.

By a resolution passed at the Annual Meeting of the Tasmanian Branch of the British Medical Association (see p. 192) the medical profession is testing its strength with the political world. There has been systematic abuse of hospitals in Tasmania for many years. Notwithstanding many denials, evidence that well-to-do patients have availed themselves of the advantages of these hospitals has been collected, and the matter has passed beyond the stage of controversy. It is now necessary for the medical profession to have recourse to united action, and to compel those in authority to recognize the principle that the hospitals exist for the benefit of the sick poor and that the beds must be reserved for them and them alone. It is unreasonable to ask the members of the honorary staff of the Hobart General Hospital to attend without payment to persons who can afford to pay. It is also contrary to accepted tenets that the Launceston General Hospital should be utilized as a private hospital, and that persons of means requiring surgical treatment should be allowed to obtain it at this institution. The action of withdrawing all members of the honorary staff will have less effect in Launceston than elsewhere, on account of the fact that the honorary staff at the Launceston General Hospital does not possess the same relations to the profession outside as is usual. The question at issue at present is limited to that of hospital abuse by well-to-do persons, and does not include the expediency of the appointment of an active honorary staff. We are, however, inclined to the opinion that unless the demands of the profession are acceded to without loss of time and qualification, the two questions will gradually merge into one another and some striking reforms in hospital administration will be witnessed in Tasmania before long. The authorities have to determine within a short time whether they will risk a violent closure of the hospitals or relinquish a political attitude. The medical profession need have no apprehension of difficultes, since it is easy to make temporary arrangements for the medical care of the poor; and the well-to-do persons who are in the habit of using hospitals can find ways and means of obtaining treatment by paying for it.

## TWILIGHT SLEEP.

Childbirth and dentition are the only physiological processes attended by pain. It has been argued that the pain associated with parturition has been accentuated, if not produced, by the artificial conditions under which the so-called civilized woman lives. The savage is supposed to suffer little or not at all when giving birth to her offspring. Notwithstanding the probability that the pain has become intensified in the course of many generations, it is not correct to regard it as a pathological sign. There is, however, no reason why physiological pain should not be lessened or diminished or the memory of this pain removed, provided that this can be accompliished with safety to both mother and child. More than a dozen years ago Krönig and Gauss described from the Freiburg Clinic their technique for inducing amnesia in the puerperal woman by means of injections of morphine and scopolamine. The idea was originally suggested by Steinbüchel. They called the analgesia produced by these drugs *Dämmerschlaf*, and claimed at that time that if applied with caution and circumspection in suitable cases no harm was done to the child, while the mother received the benefit of suffering less than she would without the injections and having no later recollection of her labour. In 1909 Krönig was able to report to the International Congress of Medicine at Buda Pest on an experience extending over 2,000 labours, during the course of which he had applied these drugs, and maintained that they were harmless to both mother and child, provided that they were applied properly, and that well-trained obstetricians and maternity nurses were available. He admitted that the method had distinct disadvantages, that it was not readily applied outside a maternity hospital, that the duration of labour was slightly increased, and that oligopnœa in the infant was not

infrequent. The method was boomed in America for some time, and a bad translation of the term employed was introduced. This expression—twilight sleep—caught on with the public, as no doubt it was intended to, and the daily press was exploited for the purpose of popularizing the method. To the lay public the situation was clear. Labour could be conducted without pain, and, consequently, a demand was made for the universal adoption of the method. The public did not trouble about indications for its use, possible disadvantages to either the mother or child, or the necessary environment for its safe application. The contention that the pain of childbirth could be removed was adopted at a platform cry by ministers or would-be politicians for the purpose of catching votes of an unsuspecting and gullible electorate. This resulted in the demand for doctors who used "twilight sleep" in their midwifery practice.

With this undreamed of clamour for an ideal, the medical profession was placed in the position of having to exercise extreme caution. In the various parts of the British Empire the method has been tried without sensational publicity, and with a judicious application of critical observation. The January number of *The Practitioner* contains a symposium on this subject, unfortunately under the Yankee title of "twilight sleep." The original term means a condition of drowsiness, with clouding of recollection, and there is no real need for a popular, catchy expression. From this collection of experiences and opinions of some eminent obstetricians it is possible to formulate definite guiding principles, which general practitioners may find useful. In the first place, there is the question whether morphine-scopolamine analgesia should be restricted to hospital practice, or to private practice, or applied in either. Sir Halliday Croom, who has used it in certain cases for eight years, is of opinion that it frequently fails in hospitals, because the quiet, darkness of the room and other essentials are unattainable in hospital. Dr. Herbert Williamson also insists on a darkened room, absolute quiet and the exclusion from the room of all persons save the nurse and doctor. Dr. J. S. Fairburn finds that ideal conditions can be obtained in a lying-in ward of a maternity home, while in general practice these conditions are not available, unless the patient is prepared to meet a greatly increased bill. Dr. Annie McCall has employed a modified method with comparatively satisfactory results at the Clapham Maternity Hospital, although she is not very favourably impressed with the advantages of morphine-scopolamine narcosis. Other authors do not suggest a restriction of the practice.

The second question is whether the injections should be given to any woman in labour or only in selected cases. Sir Halliday Croom has used it in primiparæ, especially when they are nervous, and rarely in multiparæ. He considers it valuable in tedious labours, and if properly applied knows no real contra-indications. Dr. Williamson defines "suitable cases" clearly. The drugs should not be administered until labour pains are well established and the cervix has commenced to dilate. The fœtal heart-sounds must be regular and strong, and the obstetrician must be prepared to remain with his patient until the completion of the birth. Dr. Comyns Berkeley arrived at the conclusion that the method had very little to recommend it, but more recently he has again employed it, using Haultain's method. He makes it a *sine qua non* that a very competent nurse is engaged, and that the medical practitioner is with his patient all the time, or within easy reach. Dr. Fairbairn and Dr. Hedley only give it to primiparæ.

In regard to the drugs and their dosage, Dr. Williamson lays great stress on the importance of obtaining pure scopolamine. He finds that it remains active for a considerable time when dissolved in a 10% solution of mannite in alcohol. The solution should be examined from time to time, and when it ceases to be lævo-rotatory it should be discarded. The majority of the authors give 0.01 gramme of morphine and 0.0004 gramme of scopolamine at the first injection, and do not repeat the morphine subsequently, or at times give a very small second dose. Dr. McCall dislikes morphine, and finds that 1 gramme of chloral is to be preferred. The subsequent doses of scopolamine should be 0.00014 gramme. An American practitioner, Dr. Kapp, advocates the substitution of 0.005 gramme of aceto-morphine hydrochloride without any scopolamine. He states that this drug produces analgesia, but not amnesia, and when there is uterine inertia he uses pituitrin "to force the pains." We presume that few British obstetricians will follow this practice. Dr. Williamson points out that the physiological effect of scopolamine is to dilate the pupil, to slow the pulse and respiratory rate, to dull the sensorium and abolish the memory for passing events and to induce sleep. Larger doses produce dryness of the throat and mouth, rapidity of the pulse and respirations, restlessness and delirium. Some patients are very susceptible to the drug, and forcible restraint may be required, even when small doses are employed. He considers that these partial toxic symptoms should always be avoided. There is practical unanimity in regard to the necessity for caution in the interest of the child's safety. The morphine is held responsible for baneful effects on the infant. Labour is undoubtedly prolonged by the injections, and there are slight but definite risks to the mother.

In a few words the opinions of these eminent obstetricians may be paraphrased as follows: Morphine-scopolamine injections produce amnesia, but do not reduce the pain of childbirth materially. The method is not suitable for general use, but should be restricted to those cases in which absence of noise, disturbance and light can be secured, when an experienced nurse is obtainable and the medical practitioner is able to stay with his patient. Morphine should be given once only, and the fœtal heart sounds should be watched continuously for danger signals from the infant. No further injections should be given if the mother becomes restless or shows other symptoms of an overdose.

## IMMUNITY TO EXPERIMENTAL POLIOMYELITIS.

E. C. Rosenow, E. B. Towne and G. W. Wheeler have raised an important point in the epidemiology of poliomyelitis to which attention should be directed. It is well known that recovery from an attack of experimental poliomyelitis, like recovery from spontaneous poliomyelitis, is followed by immunity. Monkeys after recovery cannot be re-infected with virulent virus. It has been stated that unsuccessful inoculation is also followed by immunity. The importance of this matter to human beings must be admitted. If a mild, atypical attack can induce an immunity to the disease, it is conceivable that infection without any signs at all may have the same effect. In other words, this would mean that the "'carrier" who had never manifested any signs of poliomyelitis might become immune as a consequence of having harboured the virus. Considerable care is required to distinguish between an individual immunity, which is responsible for the absence of signs of infection, and an acquired immunity resulting from the harmless sojourn of the virus, which is prevented from giving rise to the disease by some unrecognized event. Rosenow and his colleagues inoculated five rhesus monkeys with virus.[1] Two of them remained perfectly well, while the other three were somewhat affected, but did not exhibit the usual signs of poliomyelitis. The material employed in the inoculations was either virus, filtered virus or culture. Aftey they had determined that no definite evidence of infection had resulted from the inoculations, they tested these five monkeys for immunity, a test virus being used which proved to be highly virulent in the control monkeys. Two of the monkeys developed paralysis. The other three remained free from symptoms. It would thus appear that these three animals failed to react both to the primary inoculation and to the secondary inoculation with virulent virus. One monkey (No. 19), who had received 1.5 c.cm. of a culture of the virus intracerebrally and had been but slightly unwell for two days, was inoculated with 1 c.cm. of the virulent virus seven weeks later. It remained well. The observers took 0.30 c.cm. of its serum and mixed it with 0.70 c.cm. of the serum of one of the monkeys (No. 21) that had shown signs of paralysis after the second inoculation. To this serum they added 1 c.cm. of virulent virus. The mixture was incubated for 2½ hours, and, after having been stored on ice for 15 hours, it was injected into the brain of a fresh rhesus monkey. This monkey developed poliomyelitis on the fifteenth day, and was killed on the seventeenth day. Typical lesions were discovered. It follows that monkey No. 21 was not immune, notwithstanding the fact that it did not show signs of infection after the first inoculation. Whether monkey No. 19 was immune or not is open to argument. Rosenow and his coworkers appear to favour the suggestion that it was, despite the fact that 0.3 c.cm. of its serum was incapable of preventing 1 c.cm. of the virus from producing poliomyelitis in a fresh monkey. Since the experiment was planned in a manner which does not admit of a clear interpretation, it is impossible to determine whether an acquired immunity was present or not. Had they shown that the serum of a monkey before inoculation with virus failed to protect against the test dose of virus, and that the serum of the same monkey after two unsuccessful inoculations with virus in the same dose rendered the fresh animal resistent to a dose of test virus, it would have been certain that an artificial immunity had been produced.

[1] *Journal of the American Medical Association*, January 27, 1917.

## THE SPIRIT OF DISCOVERY.

The nineteenth century witnessed a revival as influential as that of the sixteenth century. The Renaissance of learning has been attributed to the study of Grecian literature, which engendered a spirit of inquiry as to the validity of the polity of the Middle Ages. The use of printed books spread the new spirit widely and quickly. Its propagation led to the growth of a larger toleration and of a liberality of thought which have contributed much to happier conditions of life for the mass of mankind. We stand too near the revival of the investigation of materialistic phenomena to appreciate its effects. We recognize that the study of natural objects has enlarged greatly the scope of human activities. The twentieth century sees a wider extension of this spirit of discovery. The education of youth is undergoing change. A greater number of the young from each passing generation devote some attention to the world of nature. In the study of the objects around them they gather knowledge of a world into which caprice, injustice and authority do not enter.

Medical practice has profited from the diffusion of this spirit of research. An acquaintance is now desired with all the changes occurring in the animal body. As this knowledge accumulates medicine will become more exact as a science. The rate of progress will depend on the care with which information is gathered. Every false path that is taken delays the consummation. A century may pass, many centuries have passed, while man has groped to find what lies at his doors. How long did we wait for an idea of the nature of the infection of disease! The ease with which papers may be written and published has produced an enormous medical literature. Thousands of observations and experiments bearing on the health of man are recorded each year. Many papers are the result of conscientious efforts to describe what is happening in the human or living organism. Every precaution may have been taken to ensure that the written account will correspond with the natural phenomena. Such papers contribute to the advancement of professional knowledge. Man is, however, fallible. Too often he fails to leave a sufficiently accurate account of what he has noted. In consequence, the information is found to be untrue in a few years. Whoever will turn over the pages of a periodical thirty years old will find how few articles contain matter that can be used at the present time. We recognize the hand

of genius in medicine when we read an old paper which might have been written to-day.

Investigation has often been carried on in the past by single persons, working alone, who, amid other pursuits, sought out the secrets of the Universe. Often with inadequate means the solitary worker has failed, because of the magnitude of the task attempted. To ascertain one new fact that will stand eternally used to be considered sufficient progress. It is becoming felt that more can be done to accelerate the advancement of knowledge. Organization can bring a number of workers together, who will study a phenomenon with a scrutiny that no single investigator can attempt. A study of the mineral metabolism[1] of three cows by the staff of an experimental station shows what may be done. Seventeen workers during two months were employed night and day on this work. The rigidity of the conditions ensures a greater accuracy in certain directions than had been obtained before. An enormous number of duplicate weighings and analyses were made, to give a great amount of certainty to the findings. No labour which tests results is wasted. Future investigators of similar problems will do well to consider what accuracy demands in experiments of this kind. Organization can do a great deal to teach us of disease and its treatment.

### THE NEED FOR MEDICAL MEN AT THE FRONT.

A persistent rumour is abroad that there is no need for additional medical men to volunteer for service with the Australian Imperial Forces. We have been informed officially that the need is urgent and great. The authorities in the Commonwealth have been called upon to supply many more medical officers during the current year than were supplied during 1916. Medical men at times feel that, because their services are not utilized immediately, there is no demand for them. When it is considered that the Principal Medical Officers are asked to provide a certain number of officers each month throughout the whole year, it will be recognized that some thought has to be given to the morrow. Difficulty is being experienced in discovering where the necessary number of men is to be found for future months. It will therefore be of material help to the authorities if medical practitioners who are willing to offer their services will intimate the fact to the Principal Medical Officer of their Military Division and mention at the same time when they would be prepared to go into camp, prior to leaving for abroad. The Principal Medical Officers would then be in a position to select the most suitable men month by month, and in the majority of cases would be able to inform the volunteer when his services would be required.

We regret to announce the death of Dr. W. Pritchard Bassett, of Bathurst, New South Wales. Dr. Bassett was suffering from a pulmonary affection, which ended fatally on February 21, 1917.

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It is with regret that we have also to record the death of Dr. Baxter Tyrie, which took place in Sydney last week.

[1] Mineral Metabolism of the Milch Cow, Bulletin 295, Ohio Agricultural Experiment Station, April, 1916.

## Naval and Military.

The Assistant Minister for Defence stated in the House of Representatives on February 22, 1917, that 43% of the soldiers who had been in hospital on account of wounds or sickness had returned to duty. The remaining 57% had to be replaced. The number of those killed was 18,974, of those missing 3,645, and of those taken prisoners 941. These men had also to be replaced.

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The 274th list of casualties was issued on February 23, 1917, and contained 871 names. Of these, 143 were officers and men who had been killed or who had died. In the 275th list, issued on February 26, 1917, there are names of 885 men, of whom 332 have been killed or have died. Under the heading "died of illness" is the name of Lieutenant-Colonel J. F. Flashman. Three medical officers are reported to have been wounded, namely, Captain H. I. Carlile, Captain S. M. Hansen and Captain C. O. Hellstrom. Captain C. C. Humphries is reported to be ill in hospital.

## Vital Statistics.

### SOUTH AUSTRALIA.

The Statistician's returns of the vital statistics of South Australia for the month of January, 1917, have been published in *The South Australian Government Gazette* of February 15, 1917. The calculations are based on an estimated population of 439,660, that is, the same figure as had been adopted during the year 1916. The number of births registered during the month was 1,093. The birth-rate, expressed as an annual rate, was 29.88 per 1,000 of population. This is the highest rate for January since 1912. The mean rate is 8.2% lower than the rate for the month under review.

The number of deaths registered was 421. The death-rate is therefore equivalent to an annual rate of 11.52 per 1,000 of population. The death-rate was lower in January, 1912, in January, 1914, and higher in the same month of 1913, 1915 and 1916. The rate for January, 1917, was just below the mean. Of the 421 persons who died, 73 were infants under one year of age. The infantile mortality was therefore 66.79 per 1,000 births. There were 48 persons who died after attaining their eightieth year.

Diseases of the cardio-vascular system caused 73 deaths, including 49 from organic diseases of the heart and 15 from cerebral hæmorrhage. Of the infective processes, tuberculosis caused 43 deaths, including 40 instances of pulmonary disease; diarrhœa and enteritis (surely gastro-enteritis would be a better term) caused 32 deaths, of which 24 affected infants under one year of age, pneumonia caused 15, diphtheria caused ten deaths, meningitis caused nine, enteric fever caused eight, influenza caused three, non-puerperal septicæmia and puerperal septicæmia caused two each and tetanus caused one. Cancer killed 42 persons.

The returns for the city of Adelaide are, as usual, given separately. The number of births registered during the month was 92, and the birth-rate was equivalent to an annual rate of 25.2 per 1,000 of population. This figure is lower than the average figure for the corresponding month since 1912.

The deaths occurring in Adelaide, not including those of persons not usually resident in the city, numbered 81. The corrected death-rate, expressed as an annual rate, was 22.2. The number of deaths was greater than the number registered in January of the preceding five years.

From the table dealing with the cause of death in the 81 cases very little information can be gleaned. Enteritis caused seven deaths, diphtheria caused five and enteric fever two. There were 11 fatal cardiac conditions, and seven deaths from meningitis, probably including all forms.

# Abstracts from Current Medical Literature.

## OPHTHALMOLOGY.

### (65) Plexiform Neuroma of Eyelid and Orbit.

Arnold Knapp records the case of a mentally backward girl of 17, with pigmented spots on the back and leg, a thickened right upper lid and a proptosed right eye (*Archives of Ophthalmology*, September, 1916). In infancy and later she had had several operations on her eyelid, and a neuroma was excised. A tumour of the orbit was then diagnosed, and after exposing the parts by the Krönlein method a tumour was found adherent to the optic nerve sheath. This was removed and, on examination, proved to be a neurofibroma. The frequent presence of these tumours in the eyelid and temporal and frontal regions has brought it specially to the attention of the oculist. Alexis Thompson has collected 62 cases. Aubineau and Civel describe a triad of symptoms, cutaneous tumours, tumours of nerves and pigmented spots, with general functional disturbances and arrest of development. These symptoms were present in the author's patient.

### (66) Declinations.

G. T. Stevens, in a further communication, endeavours to establish a rule associating the various heterophorias with special forms of declination of the vertical meridian of the eye (*Archives of Ophthalmology*, September, 1916). He proves to his own satisfaction that positive (that is, temporal-wards) declination of both eyes produces exophoria, and, if of unequal extent, hyperphoria as well. Conjugate declinations, that is, both eyes to the right or both to left, cause hyperphoria, and if they are unequal, exophoria. In heterophoria the declination may be easily determined, but in strabismus it is difficult. The lens clinoscope is useful in these cases. Among the effects of declination may be mentioned a facial asymmetry, such as a depression of the left and an elevation of the right eyebrow; sometimes both brows are raised on the temporal side, or the median ends are elevated. This is due to muscular contraction and spasm in the effort to correct the declinations, and is associated with much pain and discomfort.

### (67) Familial Disease of Nervous System and Eye.

After a passing reference to the association of Friedreich's hereditary ataxia with nystagmus, and of hereditary cerebellar ataxia with optic atrophy, F. E. Batten draws attention to a form of cerebral degeneration associated with macular changes seen in several members of a childship (*The Ophthalmoscope*, October, 1916). The clinical signs begin after a varying period of normal growth. They are loss of intellectual faculties, loss of vision and loss of motor power. The ophthalmoscopic appearances present grey-white discs and diffuse macular pigmentation, and on microscopical examination there is found primary degeneration in the pyramidal and Betz cells of the cortex and the Purkinje cells of the cerebellum. At the macula there is degeneration of the ganglion cells and a migration of the retinal pigment. The condition is similar to Warren Tay-Sachs' disease (family amaurotic idiocy) in its family character and clinical symptoms, and differs from it in the absence of race proclivity, absence of characteristic macular change and in the age of incidence.

### (68) Botulism.

Walter B. Lancaster relates the case of a lady, aged 23 years, who gave the following history (*The Ophthalmoscope*, November, 1916). Two hours after retiring to bed she awoke with diplopia and pain in the eye. On the following day she had vertigo, nausea and vomiting. On examination it was found that she had total ophthalmoplegia, except of the iris sphincter, dysphagia and difficulty of speech, hand tremor and muscular weakness, especially of the neck muscles. The temperature was 102° F. The serum was tested by the Wassermann test, but a negative result was obtained. Six weeks later she was able to sit up, and the eye muscles gradually improved. By excluding other possibilities a diagnosis of botulism was arrived at. Botulism is one form of meat poisoning, caused by eating sausages or canned foods contaminated by the *bacillus botulinus*, an anaerobic organism which grows best at room temperature. Gas is liberated, causing the ends of the cans to bulge; this is spoken of as "blown" cans. The toxin produced is intensely poisonous, ranking next to tetano-toxin, and, like it, selecting the nervous system. The mortality-rate is about 50%. The author adds to his excellent summary of the condition a bibliography.

### (69) Recurrent Intra-ocular Hæmorrhages.

J. Gray Clegg (*The Ophthalmoscope*, November, 1916) presents a series of cases of large recurrent intra-ocular hæmorrhages, and comments on the same. He confesses that he is at a loss to explain the cases or to suggest a reliable method of treatment. In several of the recorded cases the periodical bleeding followed injury. In these cases the inflammation was fairly obvious, and the bleeding came from the damaged vessels or from ruptured new vessels in the scar in the choroid or retina. Many causes have been suggested for the spontaneous cases. These include decrease or increase of the coagulability of the blood, circulatory changes at puberty, anomalies of the blood, such as leucæmia, and many others. Men are more frequently affected than women. Six of the recorded cases were in males and one in a female. Calcium lactate was employed in the hope of increasing the coagulability of the blood, and citrates to reduce it. Axenfeld believes that many of the patients are tubercular, and tuberculin has been given by Davis. In some of the cases thyroid and arsenic were given.

### (70) Peripheral Lesions of Shell Concussion.

From a limited though personal experience of 50 cases of defective vision ascribed to "shell shock" out of 450 ophthalmic cases, J. J. Evans has arrived at the conclusion that the ocular symptoms are generally due to peripheral lesions rather than to *commotio cerebri*, or psychic trauma (*Ophthalmoscope*, September, 1916). The analysis of the 50 cases showed that 13 were due to refractive errors, 15 to lesion of the cornea and conjunctiva, isolated cases showed iridodialysis, subluxated lens, thrombosis of the cerebral artery, hæmorrhage into optic nerve and paralysis of sympathetic. There were ten cases of ruptured choroid, and six were classed as doubtful, probably malingering, but possibly hystero-neurasthenic. The author deprecated reference to the symptoms in lay papers.

### (71) Retrobulbar Neuritis from Thyroid Extract.

Myles Standish has collected eight cases of retro-bulbar neuritis with central scotoma from the use of thyroid extracts (*Archives of Ophthalmology*, September, 1916). Henri Coppez reports five cases, four women and a man, between 30 and 40 years of age. There was in each case a loss of vision in both eyes to $^{1}/_{10}$ or less, combined with nervousness, insomnia and general weakness. The author's first case was in a woman of 69, with vision $^{6}/_{30}$ and $^{6}/_{25}$, with central scotoma. There was slight swelling of the right disc and several retinal hæmorrhages in each eye. She originally had myxœdema, and for 14 years had been taking 0.03 gm. thyroidin tablets thrice daily. The thyroid was stopped and the vision improved. The second patient, a man of 41, had half his thyroid removed six years previously, and four years later was supposed to have had the other half removed. Since then he had been taking a 0.03 gm. tablet of thyroidin before each meal. His vision was reduced to $^{1}/_{10}$ and $^{5}/_{10}$. There was a central colour scotoma in the right eye; the nerves were normal in each eye. Upon leaving off the thyroidin the vision returned to normal. The third patient was a stout woman of 33, who was taking for five days only a proprietary medicine for fatness. Both nerves were pale, and the arteries small; the vision was $^{20}/_{200}$. She omitted the nostrum, and in a month vision had improved to $^{20}/_{40}$ and $^{20}/_{70}$. There is evidently a wide difference in the tol-

eration of the drug. Thyroid should not be indiscriminately used for reduction in weight.

## LARYNGOLOGY AND OTOLOGY.

### (72) Intra-nasal Treatment of Frontal Sinusitis.

R. H. Good holds the opinion that the introduction of the intra-nasal method of treating frontal sinusitis has removed all cause for anxiety on the part of the rhinologist, who regards these cases now with the same complacency as he does antrum or ethmoidal sinusitis (*Surg. Gynecol. and Obstet.*, January, 1917). The external operation usually involves the division of the supra-orbital nerve, which leads to numbness and parœsthesia of the forehead and scalp. The external operation necessitates prolonged drainage and dressings, and a cure is not any more certain by its means than by other methods. The majority of cases get well under ordinary treatment, such as the application of cocaine with adrenalin chloride. If the sinus can be catheterized without trauma, daily lavage is excellent treatment. Should ordinary treatment fail, the anterior ethmoidal cells should be opened until a medium-sized cannula can be introduced into the sinus. Lavage is then carried out, if necessary after some of the ethmoid cells have been removed. In the author's opinion early drainage yields the best results. Should these means fail to bring about a cure, he proceeds to perform his intra-nasal operation. The anterior ethmoidal cells are cleared out with the rasp until the floor of the frontal sinus is reached. He avoids attacking the nasal spine if possible. When there are orbital abscesses he makes a larger opening by removing some of the frontal spine and perforating the *lamina papyracea* of the ethmoidal bone. Drainage is then achieved through the nose. An external opening into the abscess cavity must be made as well. The anæsthetic used is cocaine, or some of its modifications. The solution is applied by means of the applicator to the membrane of the ethmoidal region. A 1% solution of novocaine may be injected in the region of the inner canthus. The minute details of the operation are described.

### (73) Cerebellar Abscess.

In an article dealing with the symptoms and differential diagnosis of cerebellar abscess, P. D. Kerrison (*Laryngoscope*, December, 1917) admits that very little is known of the functions of the cerebellum, and consequently caution should be exercised in this regard. The symptoms of cerebellar abscess may be classified as general and focal. The general include changes of temperature and changes of pulse, headache, recurrent vomiting, nervous and mental symptoms. Among the last are intractable insomnia, and unclouded mentality associated with symptoms of intra-cranial infection. Retinal changes may be present. A sudden and rapid deterioration of the physical tone is present in some cases. Among the focal signs are nystagmus of the vestibular type, cerebellar ataxia, incoördination ataxia, occasional peculiarities of gait, diadokokinesis, loss of pointing accuracy, hemiparesis, catalepsy, and speech defects. He points out that cerebellar abscess may be present without any focal signs at all, and emphasizes this point. He instances a case in which the diagnosis was made on the strength of the history and two indefinite focal signs. The differential diagnosis is dealt with. Temporo-sphenoidal abscess can usually be distinguished by the rarity of recurrent vomiting, the absence of nystagmus, the homolateral hemiparesis and the marked mental dulness. Diffuse suppurative labyrinthitis will be confused with cerebellar abscess only during the acute stage, when nystagmus and other associated phenomena are present. In labyrinthitis nystagmus is always toward the sound ear, whereas in cerebellar abscess it is alternating, or in either direction, but usually stronger toward the side of the lesion. The author appends a summary of Barany's theory of cerebellar localization. According to this theory injury to certain cortical centres leads to a loss of correct direction sense in certain joints.

### (74) Cerebro-spinal Meningitis of Otitic Origin.

Samuel McCullagh (*Laryngoscope*, December, 1916) deals with spontaneous recovery in cerebro-spinal meningitis. He prefaces his remarks by stating that recovery from diffuse purulent meningitis is of such rarity that each case is worthy of report, in order that a mass of evidence may be accumulated for study. While all forms of meningeal involvement must be recognized, there are three types which are of particular interest to the otologist. These are meningismus, serous meningitis, and purulent meningitis. The clinical picture presented by all these types may be so similar that a diagnosis made without the study of the cerebro-spinal fluid cannot be relied upon. The author defines meningeal involvement in terms of the findings at the examination of the cerebro-spinal fluid. In meningism the fluid is clear and sterile, and there are no cytological changes. In serous meningitis, in addition to chemical changes, which he does not attempt to elaborate, the fluid may be cloudy or clear, but always contains leucocytes. In diffuse purulent meningitis leucocytes and bacteria are always present. The leucocytes are true pus cells. He finds that 31 cases of recovery after purulent meningitis have been recorded in the literature. The organisms in 11 of these cases were streptococci, while influenza bacilli, Friedländer's bacilli, *diplococcus lanceolatus*, staphylococci and other bacteria not accurately described. The author adds a case of his own. The disease in this case followed an operation of submucous resection of the septum, followed by middle ear disease in both ears, with double mastoiditis for which mastoidectomy was performed. The *dura mater* was injured in the performance of the last named operation. Some time later the cerebro-spinal fluid was clear, but contained many capsulated streptococci. The day following the lumbar puncture the temperature fell to normal and did not become elevated again. The patient had all the classical symptoms of diffuse meningitis. The author considers this case to be one of diffuse purulent meningitis of a slowly progressive type, with spontaneous recovery. He admits, however, that it might have been a localized condition dependent on some non viable organism in the cerebro-spinal fluid. In discussing the treatment of this condition he concludes on physiological grounds that surgical interference offers *per se* no hope of cure. By relieving pressure danger may be removed for a time, and curative measures are thus given a chance to act. He favours serum or vaccine therapy rather than drugs.

### (75) Conduction Aphasia in Cerebral Abscess.

E. Amberg (*Laryngoscope*, November, 1916) describes a case of abscess of the brain following middle ear disease in a man aged 37 years, in which a form of conduction aphasia was noted. After a strain the patient was unable to name objects shown to him. A radical mastoid operation was performed, and masses of cholesteatomatous material were removed. Pus led backwards and upwards, and a distinct pachymeningitis was found behind the external auditory canal. No benefit followed the operation, and consequently the brain knife was introduced through the area of pachymeningitis. Four days later the *dura mater* was incised, and the brain was explored on several occasions, with the result that an abscess cavity, probably 2½ inches in length, 1½ inches high and ½ inch deep, was discovered. After pus had been evacuated the brain started pulsating. Improvement followed gradually, but was not quite complete. The patient was unable to name a pencil, watch or keys. He had distinct tactico-optical aphasia, but when the word was spoken to him he remembered it, and could repeat it for a period not exceeding a minute and a half. The return of the employment of these missing words was accomplished later by the spelling of the words, at times mentally and at times in writing. Paraphrasing appeared as he was recovering. The names of persons gave him much trouble, and for a long time were not remembered. After he had lost the greater part of his aphasia, he found it comparatively easy to write letters without making more than one or two mistakes. The author quotes the opinion of other observers in regard to the various symptoms of conduction aphasia, and discusses the characteristics of this condition.

# British Medical Association News.

## ANNUAL MEETING.

The Annual Meeting of the Tasmanian Branch was held in Hobart on February 13, 1917, Dr. G. E. Clemons, the President, in the chair.

The following were elected office-bearers and members of the committee for the ensuing year:—

President: Dr. G. Murray Anderson.
Vice-President: Dr. D. H. E. Lines.
President Elect: Dr. A. H. Clarke.
Honorary Secretary and Honorary Treasurer: Dr. A. E. Hayward.
Members of Council: Dr. G. E. Clemons, Dr. G. H. Hogg, Dr. E. Brettingham Moore, Dr. R. Scott and Dr. Gregory Sprott.

Dr. Clemons, the retiring President, delivered an address (see page 179).

He then introduced Dr. Murray Anderson as his successor, and vacated the chair.

A discussion took place on the question of hospital abuse. It was subsequently resolved unanimously:—

> That, inasmuch as the Premier has refused to give the British Medical Association (Tasmanian Branch) a definite assurance that rich and well-to-do patients will not be admitted into State-aided hospitals, the Association has decided that, unless the assurance is given by the Premier by March 1, 1917, that such abuse shall cease, to instruct all its members to resign forthwith from the honorary staffs of such hospitals.

The Honorary Secretary was instructed to forward a copy of this resolution to the Premier.

Dr. Clemons received the hearty thanks of the members for his valuable services during his term of office and for his interesting and instructive address.

## SCIENTIFIC.

A meeting of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on February 7, 1917, Dr. R. L. McAdam, the Vice-President, in the chair.

Dr. A. W. Finch Noyes was to have exhibited a case illustrating some vaso-motor changes in the course of Raynaud's disease, but was unable to be present. The notes will be published in a subsequent issue.

Dr. Herman Lawrence showed a female patient, aged 50 years, who was suffering from a malignant growth involving the whole of the upper lip and extending subcutaneously for about one inch into the left cheek. The growth had the clinical appearance of a morphœa-like epithelioma, while the ivory-hardness just below the nose resembled to some extent rhino-scleroma. Microscopically the neoplasm proved to be of an epithelial type.

Dr. Herman Lawrence read a paper on a peculiar "blue-spot" eruption observed in soldiers. The text of this paper will be found on page 180.

Dr. Gerald O'Day mentioned that in November, 1915, he had had under his care in the Alfred Hospital a soldier with the same rash as that described by Dr. Lawrence. It was well marked on the forearm. There was neither pain nor itching. Three days before admission there had been some fever. As the hospital authorities were convinced that it was not a case of epidemic cerebro-spinal meningitis he was sent back to the Convalescent Home.

Dr. Roland Wettenhall said that he had seen patients with cerebro-spinal meningitis at Aldershot with pigmentary changes in the skin. He suggested that the "blue-spot" eruption might possibly be associated with an abortive type of cerebro-spinal meningitis.

In his reply Dr. Lawrence pointed out that he had not seen an eruption of the type described in any patient suffering from epidemic cerebro-spinal meningitis, and there were none recorded in the literature. His four patients had been sent to the hospital with the diagnosis of cerebro-spinal meningitis. All had raised temperatures; in none of them was there any pediculosis. It would be very remarkable if it were due to cerebro-spinal fever, in view of the fact that in the hundreds of cases observed this rash had not been seen before.

The Vice-President called attention to the fact that these patients had been sent to the Alfred Hospital on account of cerebro-spinal meningitis, diagnosed because of the eruption. This indicated that there was a likelihood that those who had not had a wide experience of the disease falling into that trap for the unwary. He suggested the possibility of the "blue-spot" eruption being due to a hæmolysin in the blood.

Dr. Roland R. Wettenhall read a paper on dermatology on active service with the Royal Army Medical Corps. The paper is published on page 181. He prefaced his remarks by stating that at the outbreak of war thirty Australians had presented themselves at the Commonwealth Offices in London, offering their services. They were advised to go to the War Office. Some of these men joined the Lady Dudley Hospital; twelve went to the War Office, and were attached to the Royal Army Medical Corps within two and a half months, notwithstanding the fact that there were over 500 on the waiting list. The twelve men considered themselves very lucky.

Dr. Herman Lawrence congratulated Dr. Wettenhall on his interesting paper. He was pleased to hear that the hot iron was used on the seams of the clothes in cases of pediculosis. He recommended it to be used for ironing the underpants in cases of dhobie itch. This disease had become much more prevalent in Melbourne since the soldiers had been returning from the East. He held that the hot iron was the surest means of destroying the ova of *Epidermophyton inguinale* in the clothes. The speaker agreed with Dr. Wettenhall that men suffering from mild psoriasis should continue their military duties during treatment. Unfortunately, the other soldiers in the camps objected to these men, no doubt on account of the striking resemblance between psoriasis and syphilis. He had seen many cases in which a skin affection was evidently excited by vaccination or serum therapy. In patients apparently cured of psoriasis of eczema, vaccination at times excited a relapse on the skin trouble.

Dr. D. Rosenberg was surprised to learn that there was no syphilis among the men under Dr. Wettenhall's care. Was this because he had struck a lot of moral men, was it due to prophylactic measures, or was it due to the rubbing in of mercury ointment for *pediculosis corporis*?

Dr. R. L. McAdam expressed his pleasure in listening to Dr. Wettenhall's paper. There was a double interest in the material brought before them. In the first place, there was the extraordinary efficiency of the arrangements at home for the safeguarding of the health of troops in the field. Lord Northcliffe had borne testimony in the *Times* to the wonderful efficiency of the medical arrangements for the treatment of the wounded and sick. He hoped that the absence of syphilis and gonorrhœa in the men under Dr. Wettenhall's care was not due to prophylaxis, but rather to the weighty words of wisdom addressed to the troops by Kitchener when they went to France. He had urged them to abstain from various things. He had pointed out to them that there was necessity for chastity.

In reply, Dr. Wettenhall said that he had not come across a single case of dhobie itch. He explained this immunity by the fact that the troops were Irish, from the south of Ireland. They had travelled direct to Aldershot, and thence to France. Dhobie itch was usually contracted in travelling through the tropics. The absence of syphilis applied only to the troops in France. Many things conduced to that result. Prophylaxis had nothing to do with it. Nor was it due to experience and education. One contributing factor was that they had been warned, more particularly when they went to certain localities. In other localities they were among farming people, who could take care of themselves when an advance was made by any of the soldiers. He wished to add another probable point, that the majority of the men were old Irishmen.

## MEDICO-POLITICAL.

At the meeting of the Victorian Branch held on February 7 (see above), Dr. C. B. Mollison, the Honorary Treasurer, presented the annual balance sheet of the Branch and of

the Medical Society of Victoria. If the two statements were taken together, it would be seen that the deficiency was only £14 7s. 1d., which was considerably less than had been anticipated at the beginning of the year.

## VICTORIAN BRANCH BRITISH MEDICAL ASSOCIATION.

**Revenue and Expenditure Account for Period from 13th January, 1916, to 18th January, 1917.**

### EXPENDITURE.

| | £ | s. | d. |
|---|---|---|---|
| By Medical Society of Victoria | 1,097 | 5 | 0 |
| „ *British Medical Journal* £722 7 0 | | | |
| *Less* Sales 1 9 6 | | | |
| | 720 | 17 | 6 |
| „ Postages, Duty Stamps, etc. | 13 | 19 | 4 |
| „ Printing | 22 | 16 | 6 |
| „ Stationery | 19 | 14 | 1 |
| „ Commission (New Members) | 10 | 15 | 0 |
| „ Advertisements | 5 | 4 | 0 |
| „ Travelling Expenses (Secretary) | 1 | 3 | 6 |
| „ Audit for 1915 | 2 | 2 | 0 |
| „ Sundries | 4 | 14 | 1 |
| „ Repairs | 1 | 2 | 3 |
| „ Bank Charges | 7 | 11 | 10 |
| „ Balance | 178 | 16 | 5 |
| | £2,086 | 1 | 6 |

### REVENUE.

| | £ | s. | d. |
|---|---|---|---|
| To Balance, 13th January, 1916 | 127 | 7 | 4 |
| „ Subscriptions— | | | |
| Metropolitan Members £1,161 9 9 | | | |
| Country Members 710 8 9 | | | |
| Junior Members 86 12 6 | | | |
| | 1,958 | 11 | 0 |
| *Less* Refunds 0 15 9 | | | |
| | 1,957 | 15 | 3 |
| „ Interest on Deposit, Commonwealth Bank | 0 | 18 | 11 |
| | £2,086 | 1 | 6 |

### LIABILITIES.

| | £ | s. | d. |
|---|---|---|---|
| To Balance, as above | 178 | 16 | 5 |
| | £178 | 16 | 5 |

### ASSETS.

| | £ | s. | d. |
|---|---|---|---|
| By Bank of Victoria, Ltd. | 73 | 2 | 6 |
| „ Commonwealth Bank of Australia | 16 | 12 | 11 |
| „ Trustees Organization Fund | 86 | 1 | 0 |
| „ Cash in Hand | 3 | 0 | 0 |
| | £178 | 16 | 5 |

C. STANTON CROUCH,
Secretary.

C. H. MOLLISON,
Hon. Treasurer.

Audited and found correct,
J. V. M. WOOD & CO., F.I.A.V., F.C.P.A.,
Auditors.
Melbourne, 30th January, 1917.

## MEDICAL SOCIETY OF VICTORIA.

**Revenue and Expenditure Account for Period from 13th January, 1916, to 18th January, 1917.**

### EXPENDITURE.

| | £ | s. | d. |
|---|---|---|---|
| By *The Medical Journal of Australia* | 668 | 5 | 0 |
| „ Salaries— | | | |
| Secretary £360 3 4 | | | |
| Library Clerk 36 0 0 | | | |
| Caretaker 26 0 0 | | | |
| | 422 | 3 | 4 |
| „ Library—Journals and Binding | 11 | 11 | 11 |
| „ Postages, etc. | 20 | 0 | 0 |
| „ Rates, Taxes and Insurance | 11 | 10 | 0 |
| „ Telephone | 10 | 12 | 8 |
| „ Light and Power | 5 | 4 | 1 |
| „ Audit for 1915 | 3 | 3 | 0 |
| „ Rent of Safe Deposit | 2 | 2 | 0 |
| „ Trust Deed | 2 | 2 | 0 |
| „ Bank Charges | 0 | 6 | 6 |
| „ Repairs | 7 | 2 | 8 |
| „ Balance in Bank of Victoria, Ltd. | 219 | 9 | 8 |
| | £1,383 | 12 | 10 |

### REVENUE.

| | £ | s. | d. |
|---|---|---|---|
| To Balance, 13th January, 1916 | 285 | 5 | 10 |
| „ Subscriptions | 1,097 | 5 | 0 |
| „ Sale of Assets, *Australian Medical Journal* | 1 | 2 | 0 |
| | £1,383 | 12 | 10 |

C. STANTON CROUCH,
Secretary.

C. H. MOLLISON,
Hon. Treasurer.

Audited and found correct,
J. V. M. WOOD & CO., F.I.A.V., F.C.P.A.,
Auditors.
Melbourne, 30th January, 1917.

Dr. A. E. Taylor moved and Dr. A. R. White seconded that the balance sheets be received and adopted. The motion was carried.

After the other business of the meeting had been disposed of the opportunity was given to the members to bring up other matters by the inclusion of an item "General Business" on the agenda paper. The Council had decided to give effect to this suggestion, which was brought forward at the annual meeting.

Dr. A. E. Taylor asked the Chairman whether he was aware of any urgent demand for medical men for military service.

The Chairman replied that, as far as he was aware, there was not any present need for medical men for service in camps or abroad.*

Dr. D. Rosenberg said that he had seen a published report of a deputation to the Minister of Public Health, at which it had been urged that it should be made illegal for quacks to treat infectious diseases, and that the reply had been received that the Government was powerless to prevent treatment of this kind. He desired to point out that a Medical Bill would be introduced into Parliament at the beginning of the next session, and that the time was opportune for urging the inclusion of clauses to prevent quacks from treating all forms of disease. Some of the recommendations of the English Royal Commission on patent medicines might be introduced. He trusted that the Council would consider the matter.

Dr. McAdam said that the Council had received a representation from Ballaarat concerning a case of diphtheria which had been treated by an unqualified and unregistered individual. The child had died. The Council had urged upon the Minister of Public Health the inexpediency of allowing such a thing to happen. Accordingly a deputation from the Council had waited upon him, but the Minister had not thought it advisable to assume power to prevent unregistered persons from treating these cases. Dr. McAdam promised to bring the matter up before the Council at some future date, and assured Dr. Rosenberg that it would not be left unattended to.

Dr. Rosenberg asked the Council to insist on the abolition of all unqualified practice and on the restriction of the sale of patent medicines. The Labour Party had these objects on their platform, and would be bound to support the Branch.

Dr. McAdam stated that the Venereal Diseases Act was coming into force, and its operation would be helpful for future legislation.

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A meeting of the Council of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on January 18, 1917, Dr. Ernest Jones, the Vice-President, in the chair.

It was arranged that a conference between members of the medical profession and members of the Pharmacy Board should be held, with the object of determining which drugs should be placed on the schedule of drugs required by the provisions of the Venereal Diseases Act, Section 2.

Dr. Allen Robertson gave notice of a motion to amend the rules of the Branch to provide that any member of the Branch Council who absents himself from three consecutive meetings of the Council would automatically lose his seat.

Dr. Leon Jona gave notice of a motion to amend the rule of the Branch with regard to the method of conducting the ballot at the election of members of the Council. It was determined that both motions should be submitted to a special meeting to be convened for March 6, 1917.

The Council directed the Secretary to convey expressions of their sympathy by letter to the widow of the late Dr. M. F. Kelly and to the widow of the late Dr. C. Fetherstonhaugh.

It was reported that a letter had been addressed to the Inspector of Charities regarding the abuse of public charities which had been reported to him by the Council some months previously. The following reply had been received:—

> ". . . . With reference to yours of the 2nd June, 1916, and subsequent correspondence on the subject of admitting patients to the Bendigo Hospital who are able to pay for medical treatment, I have to inform you that your complaint has been investigated by me and the practice condemned. The Honourable the Treasurer has informed the Committee that he is relying on them to carry out the spirit of the conditions of grant. I may add that whenever I find patients in a public hospital who are able to pay for their treatment I report the fact to the Treasurer, who draws the Committee's attention thereto by sending a copy of my report. I have the honour, etc., etc.
>
> (Signed) "H. C. MALCOLM,
> "Inspector of Charities."

The Council directed that letters of congratulation should be sent to Drs. J. P. Fogarty, C. H. W. Hardy and Gordon Shaw on having had military distinctions conferred upon them for services in the field.

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A meeting of the Council of the Victorian Branch was held on January 21, 1917, at the Medical Society Hall, East Melbourne, Dr. Ernest Jones, the Vice-President, in the chair.

It was resolved that steps be taken to cause a meeting of the Federal Committee to be convened at the earliest date possible, for the purpose of dealing with the question of the Venereal Diseases Act and of initiating a policy in this connexion for the whole Commonwealth.

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A meeting of the Council of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on February 15, 1917, Dr. R. L. McAdam, Vice-President, in the chair.

A discussion took place on the working of the Venereal Diseases Act, and on the establishment of clinics at the public hospitals. It was determined to call a special meeting of the Council to consider these matters. The Council decided to invite Professor Sir Harry Allen and Dr. E. Robertson, the Chairman of the Board of Public Health, to be present at the meeting.

Dr. J. Ramsay Webb was elected Representative of the Victorian Branch at the Representative Meeting of the British Medical Association for the years 1917 and 1918.

The following were elected members of the Branch:—

Dr. W. E. O'Hara, Fitzroy.
Dr. John W. Tarleton, Heidelberg.
Dr. Nathan Dennerstein, Geelong Hospital.
Dr. J. R. Anderson, No. 11 A.G.H., Caulfield.
Dr. Hugh Currell, Kensington.
Dr. Neil McColl, Warracknabeal.
Dr. V. P. Mondon, Castlemaine.
Dr. Kenneth C. Purnell, Geelong.
Dr. T. J. K. Whittam, Bendigo Hospital.
Dr. A. H. Crowley, Children's Hospital, Carlton.
Dr. F. J. B. Miller, Bendigo Hospital.
Dr. W. J. Newing, St. Vincent's Hospital, Fitzroy.
Dr. Aloysius Barbeta, Children's Hospital, Carlton.
Dr. J. P. Garvan Hurley, St. Vincent's Hospital, Fitzroy.
Dr. R. B. Loosli, Camberwell.
Dr. T. H. Donelly, Ballaarat.
Dr. A. H. Barrett, Ballaarat Hospital.
Dr. A. J. Day, Toorak Road, South Yarra.

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The following have been elected members of the New South Wales Branch:—

Dr. Walter Perry, Sydney Hospital.
Dr. G. M. Faithfull, Sydney.
Dr. R. S. Scott, Sydney Hospital.
Dr. W. F. Pattinson, Sydney Hospital.
Dr. O. C. Hellstrom, Neutral Bay.

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The following have been nominated for election as members of the New South Wales Branch:—

Arthur Christian Holt, M.B., Univ. Sydney, 1901, Beecroft.

*We have been informed officially that the authorities abroad have asked for a large number of medical officers, much larger than that instanced by Dr. Reuter Roth in his letter in last week's issue of *The Medical Journal of Australia*.

Noel Halford Franki, M.B., Ch.M., Univ. Sydney, 1913, Military Hospital, Randwick.
John Henry Victor Scott, M.B., 1913, Ch.M., 1914, Univ. Sydney, Scone.
Ralph Athelstane Noble, M.B., Ch.M., Univ. Sydney, 1916, The Hospital, Gladesville.

# Medical Societies.

## THE OPHTHALMOLOGICAL SOCIETY OF NEW SOUTH WALES.

A meeting of the Ophthalmological Society of New South Wales was held in the Sydney Hospital on February 7, 1917. Dr. Cyril Shepherd, the President, in the chair.

It was determined, on the motion of Dr. D'Ombrain, seconded by Dr. Temple Smith, that the last quarterly meeting, which the Council decided to postpone on account of the members being called up to do work on the Referee Boards, and later on account of the coal strike, be abandoned.

### Malignant Tumours of the Eye.

Dr. Hugh Allen, of Newcastle, then read a paper on some *malignant growths of the eye.*

He hoped to show by means of photographs of sections that malignant disease of the eye was not a rare occurrence, at all events in his experience. He pointed out that the majority of observers had found that sarcoma was the commonest growth affecting the uveal tract. It usually appeared as a pigmented or melano-sarcoma. It was said to occur most frequently between the ages of 50 and 60 years. Nearly all the cases he had seen had been in persons under 45 years. The growth was usually circumscribed, and had a rounded form, as long as the choroidal capsule remained unbroken. Diffuse sarcomatous infiltration was rare. Sarcoma almost invariably was a primary growth, but the choroid might be affected by a metastasis occurring from a tumour in some other portion of the body. The growth developed from the outer layers of the choroid and growing inwards detached the retina. It might undergo necrosis, and toxins might be liberated which devitalize the surrounding cells.

The life history of a sarcoma of the choroid had been divided into four periods: (*i.*) the quiescent stage; (*ii.*) the inflammatory or glaucomatous stage; (*iii.*) the extra-ocular stage, during which the growth bursts through the scleral boundary, and (*iv.*) the period of metastasis. He proposed to illustrate these stages in the series of cases.

In the first stage the disease resembled a detachment of the retina. This membrane was pushed forward by the underlying elevation, and was surrounded by a serous effusion. The vision would be affected according to the site of the growth. In one case the visual acuity had been affected owing to its proximity to the macular region. When the growth was a peripheral one the central vision might not be affected to any extent at first. If the growth was far forward it might be seen by oblique illumination through a dilated pupil. The first stage usually lasted from six to twelve months, but might be prolonged to five years.

Case I.—Mr. P., aged 38 years, consulted Dr. Allen in September, 1916, concerning a marked diminution of vision in the right eye, coming on gradually for the past six weeks. There was no complaint of pain in the eye, and his previous vision was quite good, as far as he knew. The cornea was clear, and the tension was normal in each eye. The vision of the right eye admitted of fingers being counted at one metre in certain directions. The vision of the left eye was $^6/_6$.

Retinoscopy showed a small error of hypermetropic astigmatism in each eye. No improvement was effected by glasses to the right eye. The right fundus contained a somewhat greyish area, oval in shape and the size of 1½ optic discs. One disc could be seen on the temporal side of the disc, and slightly above and external to the macula, but involving the macula slightly. A branch of the superior temporal vein could be seen crossing it at its outer edge. This greyish area was somewhat raised from the rest of the retina, and gave the impression of being solid, and not a simple retinal detachment.

Transillumination was negative, owing to the position of the lesion being too posterior.

A Wassermann test was carried out, and proved negative.

The case was possibly one of early sarcoma of the choroid. No improvement followed the exhibition of potassium iodide and mercury. Enucleation was advised, if there was any increase in size. Unfortunately, the patient had refused to come to the meeting.

The vision had become somewhat more impaired in the course of four months; but no increase in size of the growth was detected.

In the second stage symptoms of increased tension arose, due to alterations in the angle of the anterior chamber, shallowing of the anterior chamber, redness of the eye, pain in the eye and forehead, etc.

Case II. was that of a child two years old, whose chief symptoms were a little redness of the eye, some dilatation of the pupil, and a history of "crying for hours," with pains in the eye and forehead. The history of this poor little patient only extended over a few weeks, and yet on enucleation of the eye practically the whole of the interior of the eye was filled with a growth, which was apparently undergoing some degeneration, and which was causing increased tension.

A somewhat lobulated growth could be detected through the dilated pupil, occupying the lower and outer quadrants, and extending into the vitreous. The growth was somewhat reddish in colour, and some small hæmorrhagic points could be seen on its surface. A slight red fundal reflex could be seen above the site of the growth, on ophthalmoscopic examination. The tension was distinctly raised.

In the third stage an extension of the growth took place from within, outwards, and the actual growth could be seen bursting through the sclerotic.

Most of the cases of malignant growth of the eye came under the care of an ophthalmic surgeon during the stages 1 and 2. A few photographs of this patient's eye were demonstrated.

Another patient, aged 42 years, came to consult the speaker about three weeks before regarding his right eye, which had been blind for eight years, and which for the past few months had been giving him much pain, on and off. The anterior chamber was practically obliterated; the pupillary area was blocked by a greyish membrane, with numerous blood-vessels running over its surface. It appeared like a detached retina. No fundus view was possible. A slight ciliary infection was present. About 3 mm. external to the limbus, on the outer aspect of the globe, was a raised, pigmented, irregular area, about 8 mm. long by 3 mm. broad. This area was solid to the touch, and appeared to be connected with a larger and firmer mass within the eye. The tension of the eye was about + 2. The patient was advised that he had a melanotic sarcoma of the eye, and enucleation was recommended. He refused to have the eye removed, but had since consented.

This patient had not complained of any symptoms suggestive of the fourth or metastatic stage; but this did not exclude secondary deposits in the liver, spleen, or elsewhere, which might be present.

### Diagnosis.

In the early stages the differentiation between a simple and a malignant detachment of the retina had to be effected. Transillumination was a means which yielded valuable information in particular cases of detachment of the retina. Unfortunately, in the cases which he had demonstrated transillumination would not help greatly in the diagnosis. In case No. 1 the detachment was rather far back, and in cases 2 and 3 the growths were fairly obvious.

In the absence of a growth the red reflex in the pupil remained bright and undisturbed. If a growth existed the passage of the light was obstructed as the point of the instrument was placed over the area beneath which it was situated, and the pupil remained dark.

Too much reliance should not be placed upon the tension of the eyeball as a distinguishing sign between sarcoma and retinal detachment, because ultraocular tension might

be unaltered in each, although it was probably never diminished in sarcoma of the choroid, and it might be in simple detachment.

Reduced tension occurred in sarcoma of the ciliary body. In the stage of increased tension it must be distinguished from primary glaucoma. Cases of supposed primary glaucoma had been treated without benefit, and finally, when the eye had to be enucleated for recurrent pain the vague impression of "something" causing the tension to recur had been made a reality by a section disclosing a primary growth in the eye.

Other conditions which had to be differentiated from sarcoma of the choroid were glioma of the retina and detachment of the choroid.

Dr. R. H. Jones held the opinion that malignant growths of the eye were very rare. They were more frequent in the posterior portion of the eye than the anterior. He had never seen a sarcoma of the iris, and had seen only one of the ciliary body.

Dr. J. C. Halliday agreed that malignant growths of the eye were very rare. He would like Dr. Allen to mention all the points to be considered in making a diagnosis with regard to transillumination, etc. He usually relied entirely on the appearance of the growth on ophthalmoscopic examination for diagnosis in distinguishing between simple detachment and that caused by a neoplasm. He mentioned a case in which, after enucleation for glioma, a small mass formed rapidly in the vicinity of the cut optic nerve. He had removed this and sent it for pathological examination. He had not yet received the pathologist's report, and was therefore unable to say whether it was a primary or a recurrent growth.

Dr. A. E. D'Ombrain had come to the conclusion that a pinkish colour was a characteristic point in the diagnosis of new growths.

Dr. Guy Antill Pockley spoke with regard to differential diagnosis. He stated that, in addition to the condition of *retinitis exudativa*, described by the late Mr. George Coates, tubercular trouble had always to be borne in mind. Within the last month he had removed two eyes in the course of one afternoon, one for a condition of sarcoma, the other for a condition of massive tubercle of the ciliary region (in the blind eye). On making a section of these eyes it was almost impossible to tell the difference from the naked eye appearances, so closely did the tubercular mass resemble the neoplasm. He also instanced a case seen by him 2½ years ago, and also by four other ophthalmic surgeons, in which the pupil was widely dilated. There was a mass which appeared to fill the globe almost entirely. Ophthalmoscopy showed no red reflex. Three or four of the surgeons had agreed with him that they were new vessels from the ciliary region on the surface of the mass. However, the pathologist could find no evidence of any neoplasm in the specimen, and the conclusion was come to that it was the condition of *retinitis exudativa* described by Coates. He considered transillumination extremely valuable, and said that it was wonderful how far back the eye could be transilluminated by rotating the eyeball with forceps.

Dr. Cyril Shepherd thought that transillumination was very difficult to apply in some cases, and had seen several growths which were situated too far back in the globe for transillumination to be of service.

Dr. Temple Smith then read some notes on a case of melanotic sarcoma of the ciliary body.

J.B., aged 45, consulted him on September 11, 1916, complaining that he could not read with comfort with his correction, he being a hypermetrope with astigmatism. His right vision came up to $^6/_6$ and his left to $^6/_{18}$. There was good evidence that his left vision had been normal twelve months previously. He had not noticed the disability for more than a few months.

On examination in the left eye was seen a dark mass like a finger projecting into the vitreous, just behind the lens, and apparently arising from the ciliary body. The tension was not raised. The lens was slightly hazy, and there were vitreous opacities. The eye was enucleated a week later, a glass ball being inserted into Tenon's capsule by the Adams Frost method, with an excellent cosmetic result. The specimen, a very typical melanotic sarcoma of the ciliary body, was shown.

Further reference was made by Dr. Temple Smith and Dr. D'Ombrain to the case already fully reported in *The Medical Journal of Australia* (February 3, 1917, p. 101).

Dr. Temple Smith also mentioned massive retinitis proliferans as a possible condition to be excluded before making a diagnosis of neoplasm.

Dr. D'Ombrain stated that in cases with metastatic neuritis those caused by meningococci seemed to leave the eye in a better condition cosmetically than those caused by pneumococcal infection in cases in which the eye survived the infection.

Dr. D'Ombrain showed another specimen of sarcoma of the globe, which had been originally diagnosed by a medical man, who noticed the condition through the dilated pupil, in a railway carriage, and advised the case to consult him.

Dr. Cyril Shepherd pointed out that in cases of pseudoglioma from metastatic neuritis, as the condition was not often followed by *phthisis bulbi*, it was an argument against removing an eye in case of doubt, on account of the better cosmetic result obtained by retaining the blind eye than by a glass one.

Dr. Allen, in his reply, stated that he agreed with the several members who had stated that the condition was rare; but as it had happened to have fallen to him to see these three cases within a short time he thought transillumination valuable, and considered the presence of new vessels absolute proof of the presence of a neoplasm. He agreed with Dr. D'Ombrain that a pinkish appearance was a very valuable sign. In cases of glioma a piece of optic nerve should be examined microscopically, and if there was evidence of involvement the orbit should be immediately exenterated.

Dr. Cyril Shepherd read notes on some cases of glaucoma.

First Case.—Mrs. F., æt. 61 years, was attacked on November 19, 1915, with acute glaucoma of the left eye. Eserin reduced the acute condition. The vision of the right eye was $^6/_9$ with + 0.5 cyl.; the tension was 20 mm. The vision of the left eye was $^6/_{12}$, not improved. There was no cupping and no injection. The pupil measured 3 mm.; the tension was 50 (with the second weight). As the tension remained raised the eye was trephined.

About six days later lens changes occurred, and surgical treatment was not successful. The right eye was kept on under pilocarpine, and the eye remained in the same condition until shortly after she left this off.

On January 3, 1917, she got acute glaucoma in this eye. This only improved slightly with treatment. An iridectomy was performed. Before this vision, with a minus 3.5 cyl., at 100° down and out, was $^6/_9$. A remarkable point was that this eye, which originally had been corrected by a + cyl., was now corrected by a minus cyl. of the opposite axis.

Second Case.—Mrs. B., aged 41 years, was seen on February 3, 1914. The refraction with + 2 sphere and a + 0.5 cyl. was $^6/_5$; in the left eye, with + 2.25 sphere and a + 1 cyl. it was $^6/_9$. On October 18, 1915, acute glaucoma developed in the left eye, after installation of atropine by general practitioner for a foreign body on the cornea. It yielded to eserin. The eye was trephined. Two days later glaucoma developed in the right eye. This also was trephined. On February 1, 1915, *keratitis punctata* was observed in both eyes. The vision of the right eye with + 4 cyl. was $^6/_{12}$; and of the left was less than $^6/_{60}$. This condition was treated with atropine and dionine. On December 20, 1915, the tension of the left eye was + 2 and the cornea steamy. In his absence Dr. Temple Smith performed both posterior and anterior scleral puncture. The tension fell, and has remained normal since. The anterior puncture seemed to be sufficiently fistulous to keep the tension normal. On March 10, 1916, the vision of the right eye with + 4 cyl. was almost $^6/_5$; the field was reduced to 30° on the nasal side. There was no marked cupping; the tension was normal. The vision of the left eye was sufficient to count fingers at three feet; the disc was cupped and the field was reduced to 20° on the nasal side.

Dr. Jones commented on the fact of the lens changes, which frequently occured after trephinings and iridectomies

in cases where the operation had been observed by several surgeons and no suspicion existed of the lens having been touched with an instrument.

Dr. Temple Smith said that Mr. Treacher Collins had suggested that cataractous changes in the lens might be due to decreased tension of the lens capsule. He thought that the decreased tension by loss of the anterior chamber for a considerable period might cause this. Where the anterior chamber was lost for any length of time there was always a gummy exudate from the iris into the anterior chamber, which might affect the lens. For this reason he now substituted a 1.5 mm. trephine for the 2 mm. which he had previously used, as the anterior chamber reformed more rapidly.

Dr. Jones thought that one would have expected to find the condition more frequently if lowered tension were the cause, as the anterior chamber was lost after so many intraocular operations, which were rarely followed by cataract, such as optical iridectomy.

Dr. Hugh Allen thought that scleral puncture before operation for acute glaucoma was of great value and assistance.

Dr. Guy Antill Pockley had found that, in his experience, where an iridectomy was done for acute glaucoma the resulting softness of the eyeball, even after waiting a few minutes, made the fixation of the globe and the passing of the Graefe through the anterior chamber a more difficult matter.

# Public Health.

## THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending February 17, 1917:—

| | Metropolitan Combined District. Cs. | Dths. | Hunter River Combined District. Cs. | Dths. | Rest of State. Cs. | Dths. | Total. Cs. | Dths. |
|---|---|---|---|---|---|---|---|---|
| Enteric Fever | 19 | 0 | 3 | 0 | 34 | 0 | 56 | 0 |
| Scarlatina | 22 | 0 | 2 | 0 | 19 | 0 | 43 | 0 |
| Diphtheria | 48 | 0 | 7 | 0 | 52 | 3 | 107 | 3 |
| C'bro-Sp'l Menin. | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 |
| Poliomyelitis | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 |
| *Pul. Tuberculosis | 19 | 7 | 3 | 0 | 1 | 0 | 23 | 7 |

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

## THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending February 18, 1917:—

| | Metropolitan. Cs. | Dths. | Rest of State. Cs. | Dths. | Total. Cs. | Dths. |
|---|---|---|---|---|---|---|
| Diphtheria | 48 | 1 | 35 | 0 | 83 | 1 |
| Scarlatina | 15 | 0 | 8 | 0 | 23 | 0 |
| Enteric Fever | 5 | 0 | 16 | 1 | 21 | 1 |
| Pulmonary Tuberculosis | 26 | 3 | 8 | 4 | 34 | 7 |
| C'bro-Spinal Meningitis | 1 | — | 3 | — | 4 | — |

## THE HEALTH OF QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ended February 17, 1917:—

| Disease. | No. of Cases. |
|---|---|
| Diphtheria | 39 |
| Enteric Fever | 16 |
| Puerperal Fever | 2 |
| Scarlatina | 8 |
| Pulmonary Tuberculosis | 7 |
| Erysipelas | 2 |
| Poliomyelitis | 1 |

## THE HEALTH OF SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, for the fortnight ending February 10, 1917:—

| Disease. | Adelaide. Cs. | Dths. | Rest of State. Cs. | Dths. | Totals. Cs. | Dths. |
|---|---|---|---|---|---|---|
| Pertussis | 5 | 0 | 76 | 0 | 81 | 0 |
| Diphtheria | 5 | 0 | 37 | 6 | 42 | 6 |
| Pulmonary Tuberculosis | 3 | 5 | 21 | 15 | 24 | 20 |
| Morbilli | 3 | 0 | 14 | 0 | 17 | 0 |
| Enteric Fever | 1 | 1 | 8 | 2 | 9 | 3 |
| Scarlatina | 1 | 0 | 4 | 0 | 5 | 0 |
| Erysipelas | 2 | 0 | 1 | 0 | 3 | 0 |
| Puerperal Fever | 1 | 1 | 0 | 0 | 1 | 1 |

## INFECTIVE DISEASES IN WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the fortnight ended February 10, 1917:—

| Disease. | Metropolitan. Cases. | Rest of State. Cases. | Totals. Cases. |
|---|---|---|---|
| Enteric Fever | 12 | 7 | 19 |
| Diphtheria | 10 | 4 | 14 |
| Pulmonary Tuberculosis | 9 | 7 | 16 |
| Erysipelas | 5 | 0 | 5 |
| Ophthalmia | 1 | 0 | 1 |
| Cerebro-spinal Meningitis | 2 | 0 | 2 |
| Scarlatina | 2 | 1 | 3 |

## INFECTIVE DISEASES IN TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the fortnight ending February 17, 1917:—

| Disease. | Hobart. Cases. | Launceston. Cases. | Country. Cases. | Whole State. Cases. |
|---|---|---|---|---|
| Diphtheria | 10 | 3 | 12 | 25 |
| Pulmonary Tuberculosis | 3 | 3 | 2 | 8 |
| Scarlatina | 1 | 0 | 0 | 1 |
| Enteric Fever | 0 | 1 | 13 | 14 |
| Ophthalmia Neonatorum | 0 | 0 | 1 | 1 |
| Puerperal Fever | 1 | 0 | 0 | 1 |

# Special Correspondence.

(By Our Special Correspondent.)

## CANADA LETTER.

### The Canadian Medical Services.

It was learned with a good deal of surprise in October last that the medical services of the Canadian Expeditionary Force had been made the subject of severe criticism in a report prepared by Colonel H. A. Bruce, M.D., of Toronto, upon the request of Sir Sam Hughes, the late Minister of Militia. The report was prepared by Colonel Bruce in his official capacity as Inspector-General of the Overseas Medical Services, and was dated September 20, 1916. Extracts from this report appeared in the Canadian newspapers in October, and gave rise to much speculation and unwarranted criticism of the Army Medical Corps, a body that had done excellent service and that, upon the outbreak of the war, had been found perhaps better prepared than any other branch of the military forces. It was well known, not only by members of the profession, but by the public generally, that the efficiency and relative preparedness of the medical services were due in great measure to the untiring zeal and enthusiasm of the Director-General, General Guy Carleton Jones, C.M.G., and it was therefore difficult to understand the bitter strictures upon his administration contained in the confidential report. The premature publication of portions of the report was particularly resented by members of the profession who were in a position to appreciate the difficulties encountered by their colleagues overseas.

A reply to the report was written by General Jones, but was not made public, and both report and reply were submitted to a Board of Enquiry appointed by Sir George

Perley, Minister of Canadian Overseas Services. The personnel of the Board was selected, at the request of Sir George Perley, by the Director-General of the Imperial Medical Corps, and consisted of Sir William Baptie as chairman, Colonel E. C. Ashton, General Officer Commanding the Canadians at Shorncliffe, General G. F. Fotheringham, A.D.M.S., Second Canadian Division, Colonel A. E. Ross, A.D.M.S., First Canadian Division, and Lieutenant-Colonel J. M. Elder, of the McGill Military Hospital.

After a thorough and comprehensive investigation of four weeks' duration, the report of the Board of Enquiry has now been issued, a resumé of which appeared in the Canadian newspapers on January 2, 1917. As was to be expected, the criticisms made by Colonel Bruce in the main are found to be unjustified, and the defects pointed out by him are, in the opinion of the Board, due not to the system but to inexperience on the part of officers and to faults of administration in face of the enemy; moreover, the reforms suggested by Colonel Bruce are considered to be impracticable and not capable of remedying the situation. In his strictures upon the administration of General Jones and his staff the Board believes that Colonel Bruce has ignored the good work done under circumstances of novelty and great difficulty. "The Board has not hesitated to criticize those matters wherein, in its opinion, the Director of Medical Services has failed, but does so with great reluctance, for it is satisfied that much of what has been accomplished has been the result of his zeal and industry, while the good relations between the Imperial and Canadian services are largely due to his tactful performance of the many delicate duties which fell to his lot."

The Board agrees with Colonel Bruce that there is room for improvement in certain directions and that mistakes have occurred, but points out that this was inevitable under the circumstances and was due to the tremendous difficulties encountered in keeping pace with the rapid organization of the Expeditionary Force.

The feature of the Bruce report, which has attracted the greatest attention, is the proposed concentration of Canadian sick and wounded in Canadian hospitals, staffed by Canadians, and the contention that the Canadian medical corps personnel should not be associated with the Imperial service in scientific and research work. The Board of Enquiry is in "profound disagreement" with this view, and, indeed, with regard to the latter point, it is difficult to understand why such a suggestion should have been made. A heated controversy upon the proposed segregation of Canadians has been conducted in the British press, and a number of letters have been published in the *Times* objecting strongly to any preferential treatment. Apart from the fact that there are grave objections to such a policy on broad Imperial lines, the majority of the Canadians of the first three divisions were British-born, and had relatives in England, and therefore wished to go to hospitals situated near their relatives. It is stated in the report prepared by Colonel Bruce that Canadians could be treated more economically in Canadian hospitals: even were this so, the initial expense of providing hospital buildings or hutments would more than counterbalance any saving that might be effected, and at the end of the war these hutments or buildings would be thrown back upon the hands of the Canadian Government.

In this connexion the report of the Board of Enquiry reads: "There are twenty-thousand Canadians in hospitals in the United Kingdom to-day, and provision for special Canadian hospitals for them all would necessitate additional accommodation for nine thousand, without allowing for battle casualties. Deducting those provided by special accommodation and others ready to be returned to Canada, there would remain about four thousand additional beds to be provided, involving a capital expenditure of a million dollars." "The Board believes that it is quite impracticable to collect Canadian casualties at the base in France, and it would be difficult and inconvenient to direct them solely to Canadian hospitals in England."

Under the present policy a tremendous saving has been effected by the employment of Voluntary Aid Hospitals, since both building and equipment were given by private individuals. These institutions were very severely criticized by Dr. Bruce, who stated that the use of these hospitals was strongly to be condemned, that they were inefficient, expensive, and unsatisfactory, that a good deal of the surgery was bad, and that 25% of the patients were retained in the hospitals for weeks, sometimes for months, after they should be sent out. Referring to these hospitals, the report of the Board of Enquiry reads: "These latter are the outcome of the mobilization of the medical resources of the United Kingdom, and in them Canadian soldiers are not only well cared for professionally, but are comfortable, happy and at home. The Board desires to emphasize its dissent from the criticism of these institutions, which it believes to be unjust and undeserved." It appears that, at the beginning of the war, some difficulty was experienced in obtaining exact returns of admissions and discharges from these hospitals, as those in charge of them did not realize the importance of the returns. It is true, also, that from a superabundance of kindness to the patients, because they were Canadians or Colonials, men were sometimes kept too long in these hospitals, and were lost sight of by the military authorities, and even classed as deserters. This, however, is no longer the case, and returns are now promptly sent in to the proper authorities.

The Board, while not agreeing with Colonel Bruce that there is a lack of sufficient medical inspection in the hospitals, is of opinion that additional inspection of Canadian hospitals and patients in British hospitals is desirable from the Canadian standpoint. The Board is also of opinion that it would be preferable for the head of the Canadian Medical Service to remain in Ottawa as medical adviser of the Government.

Following the recommendation of Colonel Bruce, arrangements have been made for the return to Canada of as many convalescent Canadians as possible, and hospital accommodation is being provided for them rapidly in Canada. It is recommended by the Board that provision should be made for the return of convalescents by regular hospital ship rather than transport.

Another matter pointed out by Dr. Bruce was the number of unfit found among the Canadian troops upon arrival in England. The whole responsibility for this cannot be placed upon the medical authorities; but it has been due sometimes to inexperience upon the part of the medical officer conducting the examination of the recruit, and sometimes undoubtedly to a lack of care. Other instances have occurred where the opinion of the medical examiner has been overruled by the keen desire of the commanding officer to get up the strength of his battalion and to keep pace with rival battalions. In order to avoid a repetition of these conditions in future, arrangements have been made for a double examination of each recruit. A man presenting himself for enlistment is now examined first by a medical officer and then by a medical board of three practitioners.

Dr. Bruce's criticism of the medical boards was particularly drastic, but upon examination by the Board of Enquiry his statements in this connexion were modified. The Board agrees that there is necessity for a reformation in the medical board situation and in classification of casualties, and is of the opinion that an easy solution would be the adoption of the British system as far as applicable. Criticisms made concerning the availability of medical records are allowed by the Board; but it is pointed out that similar defects are common in all wars, and are the result of inexperience on the part of the officers rather than the fault of the system. In the matter of promotions the Board believes that the initial error lay in giving no lower rank than captain to officers joining the Canadian Army Medical Corps, and recommends that in future first commissions should rank as lieutenants.

## Correspondence.

### THE ANÆMIAS.

Sir,—Under the above heading in your issue of February 17, 1917, a rather violent attack is made upon the general practitioner who does not "examine samples of blood from every patient in whom he has reason to suspect some blood change," and is held to be "neglecting

his duty" "almost as much as one who does not use a stethoscope, a clinical thermometer or chemical reagents in the examination of the urine."

For the examination of blood films and the counting necessary to throw the clear light of scientific diagnosis on the condition under consideration the writer calmly tells the unfortunate general practitioner that he can save the necessary time by cutting out the "*causerie* with his patient."

My experience may differ from the average, but to be accused of wasting enough time in "*causerie*" to enable such examinations to be made comes as a joke.

How would the writer like the final word on his blood condition to come from the examination of a man who lays no claim to special skill in such? And if not, why should he expect the patient to?

Would he object to paying the pathologist for expert opinion? If so, he must be a miserably mean man.

He is, furthermore, not, in such case, "required to pay the pathologist a fee for making a diagnosis which the general practitioner should have made when he first applied to the practitioner." Such an attitude is absurd. The public expects too much as it is from one consultation, and it is this expectation of a cut-and-dried diagnosis and prognosis after one visit which leads so much to the "looseness" in speaking to which the writer so strongly and rightly—I agree—objects. The general practitioner has many faults; he may at times fail in essentials, but if he tries to do his own pathological work in time saved by cutting out "unnecessary conversation with his patients" he will indeed forfeit all "claim to the possession of God's most precious gift—intelligence."

The whole article, Sir, strikes one as being most ill-considered, and surely must have been written by one not familiar with either general practice or blood examinations—possibly both.

Yours, etc.,

G.P.

Sydney, February 19, 1917.

[G.P.'s letter raises two points of importance to the medical profession on which expressions of opinion are desirable. We therefore venture to invite general practitioners and others to contribute to this correspondence. The points may be summarized in two questions. (*i.*) Is it in the best interests of patients that the blood should be examined in all cases in which there is a reasonable suspicion of the presence of some form of blood change? and (*ii.*) Is a general practitioner competent to undertake this examination? We do not propose at this stage to attempt to justify the attitude taken up in the article referred to, but reserve that to a subsequent occasion. In the meantime we can assure "G.P." that the writer of the article has several years of experience of general practice, including lodge practice, and has many years of experience of the study of blood changes in man and in laboratory animals.]

## LODGE DOCTORS AND THE FRIENDLY SOCIETIES.

Sir,—I noticed in the daily press of a week or so ago that a Branch of the Political Labour Council desires the nationalization of medicine to be made a plank of the Labour Party's platform. If the Labour Party remains in power in the Federal Parliament it is only natural that they will endeavour to provide cheap medical attendance for their public, as well as cheap food, etc.

Are we doctors in Victoria prepared? I should say, not by any means. It is necessary, therefore, that negotiations should be at once opened with Friendly Societies, with a view to the enforcement of the Model Agreement. Such agreement would be used by the framers of any nationalization scheme as a guide to the employment of the doctors. The self-imposed truce has lasted long enough; it was made "for the present," not for the "duration of the war," and has been the cause of the attitude of stagnation taken by our representatives on the Council, so many of whom are out of touch with this particular branch of medical practice.

Country practitioners are engaged almost to a man in lodge practice, and I have not yet met one who is not anxiously waiting the promised action. If they had had the decision we would have had the Model Agreement long ago.

"Medico" thinks we would show a good example by waiting till after the war. But we are told that there will then be a time of great uncertainty and upheaval in the industrial world, and I am inclined to think we will be again put off. No; the time suits us now, and there is nothing degrading in having this business part of our profession once and for all settled. The time is passed for the question of doctors' pay to be kept in the background. I am sure that the Collins Street doctor sees to it that he obtains an adequate fee from those able to pay, so why not the lodge doctor? We have had organization meetings, and have fixed almost all the details of the Model Agreement, so let us at once do that which will bring us into line with New South Wales and New Zealand.

Yours, etc.,

F. E. LANGLEY.

Dandenong, Victoria,
February 20, 1917.

## THE MEDICAL PROFESSION AND FRIENDLY SOCIETIES.

Sir,—Will you kindly allow me to make my position clear, lest it should be thought I am one of those indifferent members of the B.M.A. whom I brand as unbusinesslike and lacking in the necessary foresight to see what a precipice is before them. I have not done contract work for over ten years, hence my lack in knowledge of certain facts which Dr. Rosenberg has thrown a flood of light upon. I am glad to know from the first paragraph of his letter that the framers of the original truce altered the phraseology from "duration of war" to "for the present." Such a fact speaks for their having a good and sufficient reason for so doing.

I do not ask for more organization. We have now quite sufficient to carry out our object. I might just as truly have said six years as "six months or more." Has not the B.M.A. for half a long life time of many and the whole lifetime of others been framing all sorts of action? But nothing has been done. Talk is cheap, but we want actions. How many men have died after years of work and worry, passing on the load which has broken their backs, their hearts, and crushed the very spirit out of them? Have not the daughters of such men been left upon the world, with the position of a lady help—a polite word for servant—or a worker in an office, if such good fortune might fall in the way? Then, again, we have the poor medical man who, through pride of profession, keeps his daughter at home in the hopes of better times, which, alas! never comes. It may be said such men are exceptional. What man will admit such a position? But I know men who are steady and good at their work whose experience is such. There is no use hiding such facts. Let us take the last two years, during which prices of the necessaries of life have doubled. Every single thing one purchases has doubled, and many trebled. All lodge members have struck, or got without striking, increased rates of pay to cope with war prices. The medical men have not only had to subsist upon the former sweating rates, but those who have remained at home from the war have had to do the work of those who went away. Yet not a grumble. Men who had extensive practices amongst the consulting classes cleared out to receive less than half their incomes in pay. I say the profession is in a position to demand consideration by the public. As matters are now, here we are with present prices, with an income which works out in value not half what it was before the war, and we are expected to grunt and put up with it. I, like Dr. Rosenberg, can see the whole profession in the gutter after the war, struggling to get from under the grasp of the public; but that seething mass will see that the medical man must, and shall, be kept under, to do what they are determined he shall do. The laws will see to that.

I say it is a crying shame that the profession should not be put upon a sound footing. If Dr. Rosenberg's statement is correct, as I feel it must be, why on earth is not some action taken before we face the inevitable downfall?

I cannot but feel that an article from you would form a good guide to action. A broad-thinking mind would do much to formulate a course devoid of prejudice wrongly held.

I would suggest the taking of the vote of the profession now in the State, and the results should lead to defi-

nite action, one way or the other, for there is no doubt there is much discontentment which ultimately cannot fail to lead to disorganization.

Yours, etc.,

MEDICO.

## Proceedings of the Australasian Medical Boards.

### NEW SOUTH WALES.

The following have been registered under the provisions of "The Medical Act, 1912 and 1915," as duly qualified medical practitioners:—

Gillies, Henry Vicars, M.B., 1916, Univ. Sydney.
Pattinson, William Frederick, M.B., Mast. Surg., 1916, Univ. Sydney.
Scott, Robert Sutherland, M.B., Mast. Surg., 1916, Univ. Sydney.
Cameron, Robert Miles Fletcher, L.R.C.P., Lond., M.R.C.S., Eng., 1903.
Shaw, Henry Charles Costello, L.R.C.P., Lond., M.R.C.S., Eng., 1884.
Clarke, Herbert Eustace, L.R.C.P., Ireland, L.R.C.S., Ireland, L.M.R.C.P., Ireland, L.M.R.C.S., Ireland, 1912.
Vale, Grace, M.B., 1894, Univ. Melbourne.

### VICTORIA.

The following have been registered under the provisions of Part 1 of the "Medical Act, 1915," as legally qualified medical practitioners:—

Alfred Austin Chancellor, c/o. Dr. Drake, Mitcham, M.B. et Ch.B., B.A.O., R. Univ., Irel., 1903.
William Joseph Newing, Maribyrnong Road, Ascot Vale, M.B. et Ch.B., Melb., 1916.
Arthur Allen Struthers, Homœopathic Hospital, Melbourne, M.D., Boston, 1915.

## Medical Appointments.

Dr. T. H. Donnelly has been appointed Officer of Health of Ballarat City, in the place of the late Dr. M. F. Kelly.

* * * * *

Dr. E. C. Hope has been appointed a medical officer in the Department of Public Instruction of New South Wales.

## Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xix.

Brisbane Hospital, Junior Resident Medical Officers.

Royal North Shore Hospital of Sydney, Honorary Assistant Surgeon to the Ear, Nose and Throat Department.

## Medical Appointments.

### IMPORTANT NOTICE.

**Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.**

| Branch. | APPOINTMENTS. |
|---|---|
| VICTORIA.<br>(Hon. Sec., Medical Society Hall, East Melbourne.) | Brunswick Medical Institute.<br>Bendigo Medical Institute.<br>Prahran United F.S. Dispensary.<br>Australian Prudential Association Proprietary, Limited.<br>National Provident Association.<br>Life Insurance Company of Australia, Limited.<br>Mutual National Provident Club. |
| QUEENSLAND.<br>(Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.) | Brisbane United F.S. Institute. |
| SOUTH AUSTRALIA.<br>(Hon. Sec., 3 North Terrace, Adelaide.) | The F.S. Medical Assoc., Incorp., Adelaide. |
| WESTERN AUSTRALIA.<br>(Hon. Sec., 230 St. George's Terrace, Perth.) | Swan District Medical Officer.<br>All Contract Practice Appointments in Western Australia. |
| NEW SOUTH WALES.<br>(Hon. Sec., 30-34 Elizabeth Street, Sydney.) | Department of Public Instruction—Appointments as Salaried Medical Officers, with duties which include the treatment of school children.<br>Australian Natives' Association.<br>Balmain United F.S. Dispensary.<br>Canterbury United F.S. Dispensary.<br>Leichhardt and Petersham Dispensary.<br>M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney.<br>Marrickville United F.S. Dispensary.<br>N.S.W. Ambulance Association and Transport Brigade.<br>North Sydney United F.S.<br>People's Prudential Benefit Society.<br>Phœnix Mutual Provident Society.<br>F.S. Lodges at Casino.<br>F.S. Lodges at Lithgow.<br>F.S. Lodges at Orange.<br>F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe.<br>Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend. |
| NEW ZEALAND: WELLINGTON DIVISION.<br>(Hon. Sec., Wellington.) | F.S. Lodges, Wellington, N.Z. |

## Diary for the Month.

Mar. 7.—Vic. Branch, B.M.A., Branch.
Mar. 9.—S. Aust. Branch, B.M.A., Council.
Mar. 13.—N.S.W. Branch, B.M.A., Ethics Committee.
Mar. 13.—Tas. Branch, B.M.A., Council and Branch.
Mar. 15.—Vic. Branch, B.M.A., Council.
Mar. 15.—N.S.W. Branch, B.M.A., last day for Nomination of Candidates for Election of Council of Branch.
Mar. 16.—Q. Branch, B.M.A., Council.
Mar. 20.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Mar. 21.—W. Aust. Branch, B.M.A., General.
Mar. 27.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Mar. 28.—Vic. Branch, B.M.A., Council.
Mar. 29.—N.S.W. Branch, B.M.A.,, Return of Ballot Papers for Election of Council of Branch.
Mar. 29.—S. Aust. Branch, B.M.A., Branch.
Mar. 30.—N.S.W. Branch, B.M.A., Annual Meeting.

### EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.